KANSAS ORTHOPAEDIC CENTER, P.A. (KOC)
7550 W. Village Circle-Suite 1, Wichita, KS 67205-9364
2450 N. Woodlawn, Blvd, Wichita, KS 67220
101 E. Fulton St, Garden City, KS 67846
316-838-2020 Office - 316-832-3925 ROI Fax
ROI email – roiinbox@koc-pa.com

REQUEST TO ACCESS AND COPY PROTECTED HEALTH INFORMATION FORM

Patient's Name: _____ MRN: _____

Patient's Address: _____

Telephone Number: _____ Date of Birth: _____

What records do you want? (Check appropriate boxes below):

- ☐ Office Notes
- ☐ Radiology Imaging CD
- ☐ KOC Therapy Notes
- ☐ Demographic Information
- ☐ Itemized Billing Statement
- ☐ KOC Testing Reports (EMG, MRI –for tests performed at KOC)
- ☐ Short/Long Term Disability or FMLA Forms (this may include your office notes and last work status)
- ☐ Entire Record (this will not include Billing Records, X-rays or records not prepared by or on behalf of KOC unless those items also are selected)
- ☐ Records not prepared by or on behalf of KOC (such as Operative Reports, Labs, EKG, outside MRI, outside PT/OT, Consults, etc.). KOC is not responsible for the completeness or accuracy of such records.
- ☐ Other (please specify): _____

In what format would you like your records produced and how would you like your records delivered?

- ☐ **Paper (choose one)**
  - ☐ Mailing Address Delivery ☐ In-Person Pickup
- ☐ **Fax**
- ☐ **Electronic-Email (choose one- if nothing selected KOC will send email encrypted):**
  - ☐ Encrypted (will need password to open)
  - ☐ Unencrypted (**Note: There is some level of risk that your protected health information could be read or otherwise assessed by a third party while in transit. By checking the box, you confirm that you've accepted this risk and request KOC to deliver your protected health information via unencrypted email).**
- ☐ **CD (choose one)-this is for medical records only, radiology images automatically come on CD**

  ☐ Mailing Address Delivery ☐ In-Person Pickup

  (choose one- if nothing selected KOC will send CD encrypted):

  ☐ Encrypted (will need password to open)

  ☐ Unencrypted (**Note: There is some level of risk that your protected health information could be read or otherwise assessed by a third party while in transit. By checking the box, you confirm that you've accepted this risk and request KOC to deliver your protected health information via unencrypted email).**

CONTINUED- SEE OTHER SIDE

Where do you want the records sent? (Check appropriate boxes and complete applicable information below):

KOC should provide my records (in the format and per the delivery method noted above) to:

- ☐ Self/Personal Representative (guardian, conservator, parent, executor, administrator of estate, person acting in *loco parentis* (such as court or agency), DPOA for health care decisions) (indicated below)

  Self/Personal Representative Name: _____
  Self/Personal Representative Address: _____
  Telephone Number: _____
  Fax Number (if applicable):_____
  Email (if applicable):_____
  Relationship to Patient: _____

- ☐ Designated Third Party (indicated below- such as attorney, provider office, insurance, employer, etc.)

  Third Party Name: _____
  Third Party Address: _____
  Telephone Number: _____
  Fax Number (if applicable): _____
  Email (if applicable): _____

-OR- I hereby authorize _____(provider or facility name and please list address, fax or contact phone number) to disclose PHI concerning the above named person to KOC.

Fees associated with copying my protected health information:

I understand that KOC may impose a reasonable, cost-based fee for providing me with a copy of my protected health information, including: (1) labor for copying the protected health information that I requested (whether in paper or electronic form); (2) supplies for creating the paper copy or electronic copy; (3) postage, if I request delivery by mail; and (4) preparation of an explanation or summary, if I requested and agreed to the fees associated with preparation of such explanation or summary. By signing below, I agree that I have been informed of the approximate fee that may be charged for providing me with a copy of my protected health information.

We aim to process this request within 7-10 business days, but it could take up to 30 days pending the volume of requests and availability of the information requested.

_____ _____
PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE DATE

**This authorization shall remain in effect for one year from the date signed above.*

Date needed by: _____

Date request received by KOC _____ Initials of KOC Staff who received request _____

Initials of staff that completed request & date completed _____

CONTINUED- SEE OTHER SIDE