COLON & RECTAL SURGEONS
OF GREATER HARTFORD

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Request for Patient Access to Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 and Connecticut law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted.

I hereby request access to health information for:

_____

_____

Print Patient's name and address

Date of Birth: _____/ _____/ _____ Social Security Number: _____-_____-_____

SCOPE OF ACCESS REQUESTED

I would like access to: ☐ All the records or ☐ The portion of the records concerning:

_____

_____

_____

Specify type of disease, accident, dates of treatment, or other portion of records you are interested in.

TYPE OF ACCESS REQUESTED

☐ **Inspection:** Please let me know when I may come to inspect the records. I understand that an employee of this medical practice may be present during the inspection and that I may not make any marks or alter the records in any way.

☐ **Copies:** I would like copies of the information requested. I understand that I may be charged a fee for the copies as explained below. Please mail the records to:

_____

☐ **Written summary:** I would like a written summary of the information requested. I understand that I may be charged a fee as explained below.

CHARGES

Copies: I understand that you may charge me a reasonable fee of up to $0.65 per page, including any research fees, handling fees and the cost of first class postage, if applicable, for copies of the information requested. I also understand that I may be charged a fee as necessary to cover the cost of materials for providing a copy of an x-ray.

☐ I hereby agree to pay the copying charges specified above. Please bill me.

☐ Please call me to let me know how much these copies will cost and to arrange payment.

☐ I am requesting these records be provided without charge because they are requested for purposes relating to a claim or appeal under a provision of the Social Security Act. Documentation of the claim or appeal is attached.

Written Summary: I understand that I will be charged a fee of _____ for the cost of preparing the summary requested.

Signed: _____Date: _____

Print Name: _____Telephone:_____

If not signed by the patient, please indicate your relationship to the patient _____

To request medical records please complete and forward the information to the following:

For patients of **DR. AYERS** please mail directly to CRSGH, ATTN: Colleen, 6 Northwestern Drive, Suite # 305, Bloomfield, CT 06002 or Fax directly to 860-242-2511.

For patients of **DR. BANERJEE** please mail directly to CRSGH, ATTN: Lauren, 6 Northwestern Drive, Suite # 305, Bloomfield, CT 06002 or Fax directly to 860-242-2511.

For patients of **DR. BROWN** please mail directly to CRSGH, ATTN: Allison, 2400 Tamarack Avenue, Suite # 200, South Windsor, CT 06074 or Fax directly to 860-648-5034.

For patients of **DR. MULLINS** please mail directly to CRSGH, ATTN: Christina, 2400 Tamarack Avenue, Suite # 200, South Windsor, CT 06074 or Fax directly to 860-648-5034.

For patients of **DR. LEWIS** please mail directly to CRSGH, ATTN: Lydia, 6 Northwestern Drive, Suite # 305, Bloomfield, CT 06002 or Fax directly to 860-242-2511.