Patient Name: _____

Address: _____

Patient Phone Number: _____

DOB: _____

SSN: _____

Attention:
HITECH Request for Medical, Billing Records (42 U.S.C. § 17935 (e))

Covered Entity Name: _____

Covered Entity Address: _____

Re: HITECH Right of Access Request for Medical Records and Your Compliance with Federal Law

Dear Records Custodian,

This is a **HITECH Right of Access Request** and asks that you provide a copy of _All records excluding invoices from January 1, 2013_ to _January 1 2018_ to the representative identified below. **Whether the records are maintained in electronic or paper form, I specifically request that you provide the records in electronic PDF format on a CD, DVD, or USB flash drive**, per the requirements of 42 U.S.C. § 17935(e)(1) and 45 C.F.R. 164.524(c)(2)(ii), as amended. These federal laws preempt applicable state laws, and provide in pertinent part:

" . . . **if the individual requests an electronic copy of such information, the covered entity must provide the individual with access to the protected health information in the electronic form and format requested . . .**"

If any of the above records are available only in paper form, **you are required** to provide the records in the electronic form and format requested. Furthermore, 42 U.S.C. § 17935(e) and 45 C.F.R. 164.524(c)(4) limit the cost of obtaining the records to the actual labor costs for reproducing them in the requested electronic format, the actual cost of the portable media (in this case, on CD, DVD, or USB flash drive), and postage. Labor costs cannot include time incurred reviewing the request, searching for and retrieving the records requested, or preparing the records responsive to the request. **The flat fee for producing the records in electronic format may not exceed $6.50**.

Pursuant to 45 C.F.R. 164.524(c)(3)(ii), I am directing you to send the requested records in electronic format directly to the following representative:

Branford Manor Settlement
c/o JND Legal Administration
PO Box 91429
Seattle, WA 98111
Email: info@branfordmanorsettlement.com

I acknowledge and consent to such, that the release of information may contain alcohol and drug abuse, psychiatric, HIV or genetic information. This release expires one year from date signed. I understand that I have the right to revoke this authorization at any time by notifying (Name of Covered Entity)_____ in writing. The revocation would not be effective for any actions taken in reliance upon this release prior to the receipt of revocation. I recognize that protected health information disclosed may no longer be protected by HIPAA or federal laws. Treatment, payment, enrollment in health plans, or eligibility for health insurance benefits may not be conditioned on my signing this authorization. A copy of facsimile of this release is as valid as the original. I understand that I have a right to a copy of this release, which I can obtain from my attorney.

Please provide the records as soon as possible, and no later than 30 days from your receipt of this letter, as required by 45 CFR 164.524(b)(2)(i). Thank you for your prompt attention to this request. If you are unable to comply with this request, please contact my attorney immediately.

Sincerely,

Patient Signature: _____ (HITECH Act permits an electronic signature)

Patient Printed Name: _____ Date Signed: _____

Relationship to patient (if applicable): _____

FAILURE TO PRODUCE THE RECORDS AS REQUESTED IS A VIOLATION OF FEDERAL LAW