PHYSICAL THERAPY SERVICES OF BROOKSVILLE, INC.

20195 Cortez Blvd.
Brooksville, FL 34601
Phone: (352) 754-4500
Fax: (352)754-9343

PATIENT ACCESS REQUEST FORM
(All requests must be returned to Brooksville location)

Patient's Legal Name: _____ Date of Birth: _____

Telephone: (_____) _____

Address: _____

Date Requested: _____ Date Request Received in Brooksville: _____

As provided by the Health Insurance Portability and Accountability Act ("HIPAA"), I am requesting that Physical Therapy Services of Brooksville, Inc. provide me with access to my health information as described below. I understand that no fee will be charged to fulfill this request of one copy of my records, and it will be ready within 5 business days of this request.

Requesting information from (specify location): ☐ Brooksville ☐ Spring Hill ☐ Bushnell

Dates of treatment: ☐ Specific dates: _____ through _____

Specific information Requested: *(check all that apply):*

☐ Initial evaluation ☐ Daily Notes ☐ Progress Notes ☐ Medical History ☐ Physician Orders

☐ Imaging Reports ☐ Billing Records ☐ All

In what format would you like to receive your records? *(choose one)*

☐ I am requesting that my requested health information be faxed to the following number: _____

☐ I am requesting that my requested health information be mailed to me at the address above.

☐ Email (We do not recommend email. There is a risk associated with transmitting protected health information through unencrypted email possibly resulting in unauthorized third parties intercepting the email.)

☐ I am requesting that my requested health information be available to me or my personal representative to pick up at the following location during normal business hours: **(circle one)** Brooksville Spring Hill Bushnell

Personal Representative Name: _____ Date of Birth: _____
Personal Representative must provide photo ID that matches the information provided above to obtain records

Personal Representative Signature*: _____ Date: _____
*Personal Representative provided a picture ID at the time of record pick up Verified By: _____

Patient: _____ Date: _____
Signature
Patient provided a picture ID at the time of record pick up Verified By: _____

Patient notified record is available: _____ Patient received record: _____