MEDICAL RECORDS REQUEST FORM

Individual's Name	Last First Middle
Home Address	
Home Telephone	

I hereby request that Falck Southeast II, Corp. ("Falck") provide me with a copy of **[please check all boxes that apply]** ("Requested Information"):

☐ My medical records.

☐ Any other personally identifiable information used by Falck to make medical and billing decisions about me.

Please check one of the following boxes:

☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the following date(s) of service:

_____

_____

☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by Falck.

I understand that any information provided to me pursuant to this request will not include (i) information compiled in reasonable anticipation of (or for use in) a civil, criminal, or administrative proceeding or as may otherwise be required by applicable law, or (ii) if I am a parent or legal guardian requesting access to a minor's information, records related to certain categories of treatment as required by law.

I understand that Falck may deny this request under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information.

I understand that Falck will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at Falck, or within sixty (60) days if the Requested Information is not maintained or accessible on-site at Falck. If Falck is unable to comply with my approved request within the applicable time limit, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing.

I would prefer to: ☐ pick-up or view the Requested Information at the appropriate Falck location; ☐ have a copy of the Requested Information mailed to me at the following address:

_____

_____

_____

I understand that Falck will charge me $0.50 per page for copying fees and that there may be an additional fee for clerical work necessary to complete my request, as well as any applicable mailing fees.

_____	_____
Signature of Patient (or Personal Representative)	Date
_____	_____
Printed Name	Relationship to Patient