

PF-5000

**REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION**

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Description of the specific information to be used or disclosed:

\_\_\_\_\_  
\_\_\_\_\_

Person or entity requesting the information and authorized to make the requested use or disclosure:

\_\_\_\_\_

Recipient of the Information: \_\_\_\_\_

\_\_\_\_\_

This information is being requested for the following purpose(s):

\_\_\_\_\_  
\_\_\_\_\_

This authorization shall remain in effect from the date signed below until \_\_\_\_\_ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization ( except to the extent that the authorization is for research related treatment, in which case you may refuse to provide that research related treatment).

**Fee:** There is a minimum charge of \$25.00 for duplicating medical records coming to you. Please allow up to 10 days for us to process your request. Medical records sent directly to your new physician will not incur a charge.

I understand that Worthy Weight Loss, PA will receive compensation from a third party for the use or disclosure of my information.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Patient Legal Representative and Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative

Medical Records Pick-up Information:

\_\_\_\_\_  
Picked up by: Name and Signature

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Form of Payment and Amount

Staff Initial and Date: \_\_\_\_\_