HARVARD
School of Dental Medicine
HARVARD DENTAL CENTER

REQUEST TO INSPECT AND/OR COPY HEA LTH RECORDS (RETAIN FOR 6 YEARS)

PATIENT, PLEASE RETURN THIS TO:

Clinical_affairs@hsdm.harvard.edu or

Privacy Officer, Harvard School of Dental Medicine/Harvard Dental Center

188 Longwood Avenue, Boston, MA 02115, Phone: 617-432-1434, Fax: 617-432-4258

PATIENT, PLEASE KEEP A COPY FOR YOUR RECORDS.

Patient Name (please print)		
Contact Telephone #		Date of Birth:
Mailing Address	_____ Street _____ City State Zip	

Which option are you requesting? Check all that apply.
I understand that if I asked to have my information duplicated, I may be charged a reasonable, cost-based fee.

- □ Review documents at HSDM /HDC
- □ Mail to address on form
- □ Email to: _____
- □ I will pick up at HSDM/HDC
- □ I give authorization for_____to pick up.
- □ Mail to NEW PROVIDER/CONSULT:
  Name:_____
  Address: _____

- □ A paper/electronic copy of only my record
- □ A reproduction of my x-ray (including a paper/electronic copy of my record)
- □ A reproduction of a model (including paper/electronic copies of my record and X-Rays)
- □ A paper/electronic copy of my billing records

Dates of record requested: _____

If electronic copy is requested, HSDM/HDC will respond within 3 business days.
If paper copy is requested, HSDM/HDC will contact me to arrange a time when I may review or pick up any requested information within 14 days, I understand that I will be notified within those 14 days if HSDM/HDC will deny any part of the request. I may then have the right to request a review, depending on the reason for denial.

(Note that HSDM/HDC may be prevented from giving you access to records involved in a legal proceeding and records protected by the Clinical Laboratory Improvements Amendments law).

Signature:_____Date: _____

If patient representative, print name: _____

****IF YOU ARE LEAVING THE PRACTICE, PLEASE PROVIDE A REASON:**

_____

For HSDM/HDC Use Only **Record request should be turned in to the keeper of records within 48 hours of receipt.**	
PSL Signature:	
HSDM/HDC Account Number:	
Practice: FGP TP Provider Name:	**Society/AG Program:**