BERKS COUNTY

CLIENT'S REQUEST FOR ACCESS TO OWN MEDICAL RECORD

Notice to Client: You may use this form to request to inspect or copy information maintained about you. This type of request is described in Berks County's Notice of Privacy Practices.

Client Name: _____

Client ID #: _____

Date of Birth: _____

Today's Date: _____

1. I hereby request my medical record as detailed below:

   - ☐ Summary of Medical Record
   - ☐ Full medical record held by this office
   - ☐ Medical record for the period _____ through _____.
   - ☐ A specific portion/section of the record as follows:

     _____

     _____

     _____

2. I hereby request to:

   - ☐ Inspect the requested records.
   - ☐ Obtain a copy of the requested records
   - ☐ Both inspect and copy the requested records

3. **I understand that unless otherwise provided by law, the charge for this record will be _____ per page for each page copied. Such fee included the reasonable costs for copying, supplies, labor and, where applicable, postage. I agree to pay this charge in full at the time I receive the copy of this record.**

4. If you have any questions relating to the inspection or copying of medical records contact:

   HIPAA Privacy Officer
   Berks County
   Beth K. Schiepan, Director of Human Resources
   633 Court Street- 8th floor- Human Resources
   Reading, PA 19601

Signature of Client:

_____ (Signature) _____ (Date)

_____ (Print Name)

If this request has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here (attach any additional verifying information):

_____

_____

_____ (Signature) _____ (Date)
Personal Representative

_____ (Print Name)