WICHITA RADIOLOGICAL GROUP, P.A.
Request for Access to Protected Health Information

Patient Name	Birth Date	Social Security Number

You have the right to inspect, or to obtain a copy of your Protected Health Information maintained in the designated record set by Wichita Radiological Group, P.A. ("WRG"). A "designated record set" includes medical records and billing information and information used to make decisions about you. It does not include (a) duplicate information maintained in other systems; (b) data collected and maintained for research; (c) data collected and maintained for peer review purposes; (d) psychotherapy notes; (g) information compiled in reasonable anticipation of litigation or administrative action; (h) employment records; (i) student records; and (j) source data interpreted or summarized in the individual's medical record (example: pathology slide and diagnostic film).

Your request for access must be made in writing using this form. If your request is granted, WRG will make every reasonable effort to provide the Protected Health Information requested in the format requested by you if it is readily available in such format, including electronic formats, if such information is maintained electronically. If it is not readily available in such a format, WRG will make every reasonable effort to provide access to the Protected Health Information in a legible, hard copy format or in such other form as agreed upon by you and WRG. If the requested information is stored electronically but not readily available in the requested electronic format, WRG will provide such information in a readable electronic form agreed upon by you and WRG. Your request may be denied under certain circumstances and, in some cases, you may have a right to a review of such denial.

WRG may provide you with a summary of the Protected Health Information requested, in lieu of providing access to the Protected Health Information, or may provide an explanation of the Protected Health Information to which access has been provided, if you agree in advance to the summary and explanation and to the fees imposed for such summary or explanation.

I hereby request that WRG copy the following records:

____

Description of records to be copied including treatment dates

I hereby request WRG transmit the requested records to (check me or clearly identify a person you wish to designate to receive such records): me: ______ designated individual: ______________________________

I hereby request WRG to transmit the requested records to me or my designated individual at: ______________________

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In signing this request, I understand and agree to the following (initial in the space provided):

_______ I agree to pay for the cost of copying the requested records; or

______ WRG has advised me of the fee it will assess to provide a summary and explanation of the requested records and I agree to receipt of a summary and explanation of the requested records in lieu of a copy of such records and agree to pay the agreed upon fee for such summary and explanation.

______________________________ *Signature of Patient/Legal Representative*

______________________________ *Description of Legal Representative's Authority to Act for Patient*

______________________________ *Printed Name of Legal Representative*

______________________________ *Date*