



**Request by Patient to Access Protected Health Information**

The Health Insurance Portability and Accountability Act of 1996 establishes an individual's right to access and receive copies of their protected health information (PHI). Neurocare, Inc. requires that all requests for access and copies be made in writing using this form. Neurocare, Inc.'s Privacy Officer will review all requests. Neurocare, Inc. has thirty days to respond to your request. Neurocare can obtain an additional thirty days to complete this request with prior notice to you. This may be requested in cases where your information may not be active and is stored off-site in archives.

**Patient Name:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

**Date of Request:** \_\_\_\_\_

**Requested Information:**

**Please provide specific details and dates:**

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

**How would you like to receive your results?**

( ) U.S. Mail – Provide address: \_\_\_\_\_

( ) Fax – Provide Fax #: \_\_\_\_\_

( ) **\*\*Email** – Provide Email Address: \_\_\_\_\_

***\*\*By signing below, I acknowledge that I understand the potential risks associated with transmitting my protected health information through non-secure email.***

**Patient Signature (or authorized individual)** \_\_\_\_\_

**If authorized individual, relationship to patient** \_\_\_\_\_

Return this completed form to:

Neurocare, Inc.  
70 Wells Avenue, Suite 201  
Newton, MA 02459  
Attn: Privacy Officer

Or Fax: 617-796-9099

**For practice use only**

**NEUROCARE, INC.**

- Accepts       Denies       Accepts in part (see comments below)

**Privacy Officer Signature:**

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**Date of Review:**

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**Comments:**

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