John P. Muffoletto, M.D.
2751 DeBarr Rd. Suite 290
Anchorage, AK. 99508
Phone (907)276-1046
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PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

SECTION A: PATIENT TO COMPLETE THE FOLLOWING INFORMATION

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____

PATIENT ADDRESS: _____

PATIENT TELEPHONE NO: _____

REQUEST:

I hereby request that John P. Muffoletto, M.D. provide me with (check all boxes that apply):

☐ **Access to:** ☐ **My own copy of the requested information (check all boxes that apply)**

☐ My Medical records.

☐ My billing records.

☐ Any other personally identifiable information used by John P. Muffoletto, M.D. to make medical decisions about me. Please describe:

_____

☐ I am interested in access to or obtaining a copy of all requested information maintained by John P. Muffoletto, M.D.

☐ I am interested in accessing or obtaining a copy of the requested information relation to the following time period: _____through_____.

☐ I would prefer to receive the requested information in the form of a summary prepared by John P. Muffoletto, M.D. at a cost to me of $_____.

☐ I wish to receive the requested information in the following format.

☐ Photocopies ☐ Electronic transmission (if available) ☐ Other (if available)_____

☐ Name(s) of person who is allowed access to my medical records:

_____

Signature of patient or legal representative _____

Printed name of legal representative _____

Relationship to patient _____