Michael S. Meininger, M.D.
36880 Woodward Ave., Suite 203
Bloomfield Hills, MI 48304
248-269-4100 Fax:248-480-2399

REQUEST FOR ACCESS TO MEDICAL RECORDS

Notice to Patient: You may use this form to inspect, copy or request information maintained about you. This type of request is described in our Practice's Notice of Privacy Practice.

PATIENT NAME: _____
(Print or Type)

DESCRIPTION OF RECORDS REQUESTED:
(Please describe the records or type of records requested. Please also let us know how far back in time you want to access records.)

_____

_____

_____

_____

SCOPE OF REQUEST: Please let us know if you want to:
_____ I would like to inspect the requested records.
_____ I would like to obtain/send a copy of the requested records:

Request Records From: **Michael S. Meininger, M.D.**
36880 Woodward Ave. #203
Bloomfield Hills, MI 48304
Phone#: 248-269-4100
Fax#: 248-480-2399

Send My Records To:
_____
_____
_____
_____
Phone/Fax#: _____

FEE FOR COPYING REQUESTED RECORDS:
Our Practice may charge a reasonable fee for the cost of copying your requested records. We may also charge you for postage if you ask us to mail your requested records.

CONTACT PERSON:
Please contact our Practice's Privacy Official if you have any questions relating to request to inspect or copy records.

PATIENT INFORMATION & AUTHORIZATION

Patient Name (Print) _____ Signature of Patient: _____
DOB: _____
Date: _____

For Personal Representative (if applicable)
Personal Rep Name: _____
Describe Personal Rep Relationship: _____
(Parent/Guardian/Power of Attorney/etc.

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above:

Signature of Personal Representative: _____ Date: _____