Advanced Infusion Care®

RECORDS REQUEST FORM

Patient name: _____
First Middle Last

Home address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ DOB: _____

I hereby request that **AIS Healthcare** (the "Company") provide me with the "Requested Information" checked below (please check all boxes that apply):

- ☐ My medical records
- ☐ My billing records
- ☐ Any other personally identifiable information used by the Company to make medical decisions about me

Please also check 1 of the 2 boxes below:

- ☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through _____
- ☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by the Company

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or other information limited or restricted by applicable law. *If I am a parent or legal guardian requesting access to a minor's information, I further understand that I may not be provided access to records related to certain categories of treatment as required by law.*

I understand that the Company may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed healthcare practitioner selected by the Company who did not participate in the Company's decision to deny my request.

I understand that the Company will notify me of its decision to approve or deny my request to obtain a copy of the Requested Information within thirty (30) days of receiving this request.

Please select how you would like to receive your Requested Information (check 1 box):

☐ Email: _____

☐ Fax: _____

☐ Mail Address: _____

City: _____ State: _____ ZIP: _____

I understand that the Company may charge me $0.10 per page with a maximum charge of $50.00 for the labor associated with copying the records that I am requesting (whether in paper or electronic form) and for the supplies to create the paper copy or electronic media, as well as the actual costs of postage if I request that the information be mailed to me.

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed Name of Personal Representative Date

_____

Relationship of Personal Representative to Patient

After you have completed this form, please return it to the Compliance Department by mail, by facsimile as indicated below, or by email attachment, which you can complete via the QR code below:

AIS Healthcare
623 Highland Colony Parkway, Suite 100
Ridgeland, MS 39157
Attention: Compliance Department

Fax Number: 877.415.4050
Email: AICrecords@aiscaregroup.com

SCAN HERE TO SUBMIT
YOUR COMPLETED FORM