DATE

PROVIDER NAME
PROVIDER ADDRESS

Re: Patient:
Date of Birth:
Dates of Treatment:

Dear Patient Records Department:

I request a color copy of my entire office and/or hospital record (my "Protected Health Information" and/or "Electronic Medical Record") **on a CD, thumb drive or email in .pdf format that is OCR searchable and unencrypted**. This is a "Personal Use Request" as that term is defined in 45 CFR § 154.524(c)(4).

Please send the records to my email, at CLIENT EMAIL, or if you choose to send the records by mail please send them to me at:

Client name
Client address

My Designated Record Set is being requested in accordance with the requirements of HITECH Act, and specifically, 42 U.S.C.§17935(e)(1), and its implementing regulations, 45 CFR 164.524(c)(4)(i).

Pursuant to 42 U.S.C.A.§17935(e)(2), the fee that you may charge for providing the requested documents in electronic form may not be greater than your labor costs in responding to this request. Since the requested records are required by law to be in electronic form, **your fee should not exceed $6.50. If your fee is in violation of this law, a complaint will be made to the United States Department of Health.**

YOU ARE REQUIRED TO PROVIDE THE RECORDS WITHIN 30 DAYS.

Sincerely,