



# BONE & JOINT CLINIC OF BATON ROUGE

Medical Records Department  
P. O. Box 98035, Baton Rouge, LA 70898

Phone: 225-766-0050 ext. 5001 Direct Fax: 225-819-5098 [medicalrecords@bjcbr.com](mailto:medicalrecords@bjcbr.com)

## Request for Inspection and/or Copy of Protected Health Information

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to request the opportunity to inspect and copy health information that pertains to you. **BONE & JOINT CLINIC OF BATON ROUGE, INC.** can evaluate your request to inspect these records and can either grant or deny the request. If such request is denied, an explanation will be given as to the reason why the request will not be granted. In the event that your inspection request is denied, you may request that someone review the decision other than the person who originally denied the request.

Patient's Name: \_\_\_\_\_ DOB \_\_\_\_\_ Last 4 SSN \_\_\_\_\_

Requestor (If not patient): \_\_\_\_\_ Relationship to patient \_\_\_\_\_

I hereby request to inspect and/or copy the health information pertaining to the above named patient maintained at Bone & Joint Clinic of Baton Rouge, Inc. Please provide me with access to and/or a copy of the following information (please be specific):

**Paper Copies of Chart (no charge for 1<sup>st</sup> set provided)**

Date of Service (approx.) \_\_\_\_\_

Description \_\_\_\_\_

**MRI / X-Ray Images (burned on CD) \$10**

Date of Service (approx.) \_\_\_\_\_

Description \_\_\_\_\_

\_\_\_\_\_  
Patient's / Requestor's Signature

\_\_\_\_\_  
Date

**Please Choose ONE of the following:**

- I am currently in the clinic and will wait for my copies (takes approx. 10-15 minutes).
  - I will pick up my copies- please wait for phone call before coming to pick up. Phone # \_\_\_\_\_
  - Fax copies to ME. My fax # is: \_\_\_\_\_
  - Mail copies to ME. My address is: \_\_\_\_\_
- Please note that we are unable to email records at this time.

**For Office Use Only**

\_\_\_\_\_  
**BJCBR Employee**

\_\_\_\_\_  
**Date Received**

Reviewed by: \_\_\_\_\_ Review Date: \_\_\_\_\_

This request is hereby \_\_\_\_ Granted \_\_\_\_ Denied  
If granted, released #pages \_\_\_\_ #Film CDs \_\_\_\_ #Films \_\_\_\_

\*Sent electronically for review by Chief Privacy Officer

**Charges**

- Papers \_\_\_\_\_
- Radiology CD \_\_\_\_\_
- Radiology Films \_\_\_\_\_
- Postage / Handling \_\_\_\_\_
- Total \_\_\_\_\_

**-OR-**

- No Charge