



www.DrWeightControl.com

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Request for Access to Patient's Health Information

As a patient of the Physician's Weight Control and Wellness, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit to the Privacy Officer. When received by the Privacy Officer, he/she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer, Christine Bowen at 817-277-3469.

Patient Information:

Patient Name _____ Birth Date _____

Address _____ Phone _____

I would like a copy of my protected health information:

- | | | |
|--|---|---|
| <input type="checkbox"/> Records dated between _____ and _____ | | |
| <input type="checkbox"/> Most current blood work | <input type="checkbox"/> Most current EKG | <input type="checkbox"/> All records |
| <input type="checkbox"/> All blood work in record | <input type="checkbox"/> All EKGs in record | <input type="checkbox"/> Saliva results |

What is the reason you are requesting these records? _____

☐ Fax my records to: _____ Fax # _____

☐ I will pick up a copy of my records when they are ready.

☐ I would like to have a copy of my records mailed to the following physical address:

I understand that the Physician's Weight Control and Wellness is given thirty days to process my Request for Access if my information is maintained on-site and sixty days if the information is maintained off-site. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions.

Signature: _____ Date: _____

Note: This signed request is for this access/release only. You must complete another request form if you require additional information that is not within the records release dates you listed on this form.

NOTICE: *Because email is not secure, please be aware of associated risks of email transmission. Because you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We cannot guarantee that information transmitted will remain confidential.*