

**LAKE SHORE MEDICAL ASSOCIATES, LTD.**  
2734 N. LINCOLN AVENUE  
CHICAGO, IL 60614-1321  
(773) 525-7720

**Patient Records Access Form**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I would like to  inspect  
 obtain a copy of  
 both inspect and obtain a copy of  
my protected health information records at this practice.

**Inspection**

I would like to visually inspect the following:

- My complete record at this practice.
- My record at this practice for time period \_\_\_\_\_ through \_\_\_\_\_.
- A specific section of my record (please describe): \_\_\_\_\_  
\_\_\_\_\_

I would like to inspect my records on the following date and time: \_\_\_\_\_

**Obtaining a Copy**

I would like to obtain a copy of the following:

- My complete record at this practice
- My record at this practice for time period \_\_\_\_\_ through \_\_\_\_\_.
- A specific section of my record (please describe): \_\_\_\_\_  
\_\_\_\_\_

I request the record in the form of:

- Readable hard copy.
- A summary in lieu of receiving the complete record.
- Other format agreed to by this practice and myself:  
\_\_\_\_\_

**Delivery**

- I would like to pick up the copy of my records on the following date and time:  
\_\_\_\_\_
- Please mail the copy of my records to: \_\_\_\_\_  
\_\_\_\_\_

Your agreement will be requested in advance for any copying or mailing fees that the practice incurs to fulfill your request. This practice has the right to deny access, in whole or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings, were provided by a non-provider under promise of confidentiality concerning their identity, or could place in danger your life or the lives of others.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_