

**TULANE UNIVERSITY MEDICAL GROUP**  
**ACCESS PROVIDED TO PATIENT OR**  
**PATIENT'S PERSONAL REPRESENTATIVE**

**Patient Name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

*This form must be completed by the manager of the specific site or the TUMG Billing Office when a patient is granted access to his or her health information, or the patient's personal or legal representative is granted access to the patient's information. The manager completing this form should remember to print his or her name where provided and sign and date the form.*

**RECIPIENT OF ACCESS**

*Check the appropriate box:*

**Who received access to the information?**     Patient     Patient's Personal Representative

**INSPECTION**

*Complete this section if the patient or personal representative was permitted to inspect information:*

**What information was the patient or personal representative permitted to inspect?**

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**When did the patient or personal representative inspect this information?**

(MO/DY/YR) \_\_\_/\_\_\_/\_\_\_

**COPIES**

*Complete this section if the patient or personal representative was provided with copies of information.*

**What information was the patient or personal representative permitted to copy?**

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**How were these copies provided?**

Check one: PICK UP \_\_\_\_\_ BY MAIL \_\_\_\_\_

Mailing Address:

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**When were these copies provided?** (MO/DY/YR) \_\_\_/\_\_\_/\_\_\_

**What fee was charged to the patient or personal representative for providing these copies?**

\$ \_\_\_\_\_

**SUMMARY OR EXPLANATION OF INFORMATION**

*Complete this section if the patient or personal representative was provided with a summary or explanation of the requested information.*

**What is the title of that summary or explanation?**

\_\_\_\_\_  
\_\_\_\_\_

**Has a copy of the summary or explanation been added to the patient's medical record?**

Yes \_\_\_\_\_ Date \_\_\_\_\_

**Who prepared the summary or explanation?** \_\_\_\_\_

**What fee was charged to the patient for providing this summary or explanation?**

\$ \_\_\_\_\_

\_\_\_\_\_  
Signature of the manager of the specific site

\_\_\_\_\_  
Print name of the manager of the specific site

\_\_\_\_\_  
Date

***REMINDER:***  
**ADD THIS FORM TO THE  
PATIENT'S MEDICAL RECORD (OR  
BILLING RECORD FOR FPP  
CLAIMS) ALONG WITH COPIES OF  
ANY SUMMARIES OR  
EXPLANATIONS PROVIDED TO  
THE PATIENT**