ITAMAR MEDICAL
PATIENT REQUEST TO ACCESS HEALTH INFORMATION

Date of Request: _____
Patient's Name: _____
Last First Middle
Date of Birth: _____
Phone Number: _____

I hereby request _____ [NAME OF PATIENT'S HEALTH CARE PROVIDER] direct Itamar Medical to provide access to or a copy of my --

☐ Sleep Study Report

Note: Fees may apply to certain requests.

Date/Time Period
Specify date/time period for the information above:

_____

Format
☐ Paper Form
☐ Electronic Format (i.e., CD)

Delivery
☐ View Only: Date: _____
☐ Pick-up: Date: _____
☐ Mail: Date: _____

Information Excepted from Request
I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law. If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law.

Process if Request Denied
I understand that my healthcare provider, or Itamar Medical in its role as a Business Associate to my healthcare provider, may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner at my healthcare provider who did not participate in the decision to deny me access.

I understand that Itamar Medical or my healthcare provider will notify me of the decision to approve or deny my request to inspect the Requested Information within five (5) working days of receiving this request and within fifteen (15) days after receiving this request if my request is for copies, unless I agree to additional time to respond. My healthcare provider, or Itamar Medical as its business associate, will provide me with a summary of the Requested Information within ten (10) working days of receiving my request, or within a maximum of thirty (30) days if I am notified that more time is necessary.

Fees

I understand that [Itamar Medical, in its role as a Business Associate to my healthcare provider] may charge me a fee for the copying services necessary to complete my request, as well as any applicable mailing fees.

Signature of Patient (or Personal Representative)	Date
Printed name of Patient or Personal Representative	Date
Relationship of Personal Representative to Patient	