[Insert Letterhead]

**Request for Access**

Please complete this form and give it to the [Privacy Officer or designee] with a completed authorization to disclose protected health information.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request the following PHI be released from my medical record(s):

□Emergency Room Record □Laboratory Report(s) □Radiology Report(s) □Pathology Report □Immunization Record □Radiology film/imaging studies/tracing/media □Itemized Billing Records

□Abstract/Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultations, and Test Results)

□Test Result(s) of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Covering the period of healthcare from: Specific Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you wish to review your information and do not want information copied or reproduced, initial here \_\_\_\_\_\_\_\_\_.

|  |  |  |  |
| --- | --- | --- | --- |
| Format (electronic format, paper copies etc.): |  | Delivery (via mail, email, on-site pick up etc.): |  |

**Note:** Protected health information provided on portable electronic media or by email will not be encrypted and may be at risk for inadvertent disclosure if it is lost or stolen. By requesting the use of portable electronic media or email, you accept this risk.

I understand that the HIPAA Privacy Rule sets forth certain types of protected health information that are not subject to a request for access, including, but not limited to, a request for access to psychotherapy notes or a request for access to protected health information when a licensed health care provider has determined that access is likely to endanger the life or physical safety of any person. In such a case, [Insert Covered Entity name] does not have to grant me access to the requested protected health information and will provide me with notification of the denial, in writing, the reason for the denial, and whether the denial is subject to an appeal.

I also understand that [Insert Covered Entity name] may impose a reasonable, cost-based fee for providing me with a copy of my protected health information, including: (1) labor for copying the protected health information that I requested (whether in paper or electronic form); (2) supplies for creating the paper copy or electronic media if I request that the electronic copy be provided on portable media; and (3) postage, if I request delivery by mail.

|  |  |  |
| --- | --- | --- |
| Patient or personal representative signature  (and relationship of personal representative) |  | Date |

For [Insert Covered Entity name] Use Only

Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Receipt Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deadline to Respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deadline Extended: \_\_\_\_\_\_No

\_\_\_\_\_\_Yes Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date written notification given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New deadline to respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Access Provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On-site: \_\_\_\_\_\_

Email: \_\_\_\_\_\_\_

Paper: \_\_\_\_\_\_\_

Other electronic media: \_\_\_\_\_\_\_

Date Denial: \_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Privacy Officer/Designee Date