**REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION**

You have the right to request access to protected health information about you that is maintained by [COVERED ENTITY]. [COVERED ENTITY] will evaluate your request and will either grant your request or explain the reason why the request will not be granted no later than thirty (30) days from receipt of your request. [COVERED ENTITY] may charge you a reasonable cost-based fee for your request. Your right to access does not extend to information complied in reasonable anticipation of litigation; psychotherapy notes; information not maintained by [COVERED ENTITY]; or other information not subject to the right of access under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule.

**PART A: Patient Information**

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_\_\_\_Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART B: Scope of Access Request**

I request a copy of my protected health information (PHI) held by [COVERED ENTITY] for the following date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request the following protected health information (PHI)

* All records
* Abstract report
* History and Physical
* Laboratory Reports
* Radiology reports
* Progress notes
* Consultation reports
* Radiology images/CD
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART C: Form, Format, and Manner of Access**

I would like to receive my records in the following format:

* Paper
* CD
* Email
* I wish to pick up my records
* I wish to inspect/review my records
* Please send copies of my records to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Email is not a secure means of communication. We will encrypt email communications of your records unless you tell us to use unencrypted email.

If you do NOT want us to encrypt our email communications to you, please initial here: \_\_\_\_\_\_\_

If I submit this access request form and request to have my information sent to a third party, I understand that information contained in my medical record may contain HIV/AIDS testing, results, and/or treatment records; mental health diagnosis and/or treatment records; alcohol and/or drug abuse diagnosis and/or treatment records.

**Processing Your Requested Information:**

We may charge a fee for copies of requested health information to cover cost of labor, supplies, and/or postage, if mailed to you. We will inform you of the total charges before providing the requested copies.

We will respond to your request within 30 days from date of receipt. Actual turnaround time is typically shorter. We will require an additional 30 day extension if your health information is not readily accessible or is maintained in an offsite storage facility and will notify you if we need this extension of time. We appreciate your patience while we process your request.

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

Signature of patient (or legal guardian or personal representative)

If signed by Personal Representative, relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: