Protected Health Information Access Request Form

Patient Information

Patient Name: ____ DOB: _______________

Requestor (If different than above): _____________________________ Relationship: ______________

Requestor Phone Number: _________________________________

Requestor Email Address: __________________________________
(If applicable, please include a copy of guardian or personal representative appointment order)

Information Requested

1. I hereby request that the Family Care Center provide me with access to my Protected Health Information as checked below. (Check all that apply)

Complete Health Record

Activity Documentation

Admission/re-admission Documents

Advance Directives

Assessments, flowsheets

Care Plan

Informed Consent

History, exams, and other records

Minimum Data Set

Medication and treatment records

Nursing Documentation

Progress Notes

Reports (Lab, x-ray, other)

Test results

Face sheet

Other (please describe): ____

2. I request access to the health information as indicated above covering the following dates:

From Date: ________________ To Date: _________________

3. I would like to receive the requested information in the following format:

Printed Paper Copies: (Cost is calculated for supplies and labor not to exceed $25.00 plus postage)

Pick-up Records

Mail Records (Postage charges are applied)

Fax Records to: _______________________________ Attn:_________________________

Electronic Copy: Electronic copies sent through compatible secure email.

Compact Disk Media: ($6.50 per disk)

Secure Email: $6.50 flat fee. Electronic mail may be sent with compatible email service.

Inspection: No Charge. A date, time, and location to view the record will be arranged for you.

If mail or fax is requested, send the requested information to:

Name: ______________________________________

Address: ______________________________________

City, State, Zip: ______________________________________

Fax Number: ______________________________________

Required Signatures

Signature of Patient:		Date:
Patient Name:		
Signature of Personal Representative: (if applicable):		Date:
Personal Representative Name:		

To prevent delay in completing your request, access request forms that are sent via email or mail, must be notarized in order to confirm the identity of the requesting person.

NOTARY INFORMATION

State of Colorado)

) SS.

County of _________________________)

Subscribed and affirmed before me

this ___________day of _______________, 20 ______

____

Notary Signature

Protected Health Information Access Request Form

Facility Response

The request for access or copy is: Accepted Denied

If denied, check the reason for denial:

- ☐PHI is not part of the patient's Designated Record Set
- ☐Federal law forbids making the requested information available to the patient for inspection (e.g., CLIA or Privacy Act of 1974)
- ☐The requested information is psychotherapy notes
- ☐The requested information has been compiled for legal proceeding
- ☐The requested information was obtained under promise of confidentiality and access would be reasonably likely to reveal the source of the information
- ☐The requested information is temporarily unavailable because the individual is a research participant
- ☐Licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others
- ☐Licensed health care provider has determined that the requested information identifies a third person who may be physically, emotionally, or psychologically harmed if access to the information is granted
- ☐Licensed health care provider has determined that access to the requested information by the patient's personal representative could result in harm to the individual
- ☐We are acting under the direction of a correctional institution and letting the inmate access or obtain a copy of the requested information would jeopardize the health, safety, security, custody, or rehabilitation of another person at the correctional institution
- ☐The requested information is not maintained by our Facility

RIGHT TO REVIEW

- ☐Yes
- ☐No (contact the Facility HIPAA Compliance Officer with any questions)

You have the right to file a complaint with the Family Care Center and the Secretary of Health and Human Services, Contact the Facility HIPAA Compliance Officer for additional information.

Completed By:	
Signature of FCC Representative:	
Date:	