



# 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            | Minimum Data Set                 |
| Activity Documentation            | Medication and treatment records |
| Admission/re-admission Documents  | Nursing Documentation            |
| Advance Directives                | Progress Notes                   |
| Assessments, flowsheets           | Reports (Lab, x-ray, other)      |
| Care Plan                         | Test results                     |
| Informed Consent                  | Face sheet                       |
| History, exams, and other records |                                  |
| 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

Stat 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:	