Health Care Component: ______________________________
Unit Privacy Officer: __________________________________

Access Request Form for Protected Health Information

Instructions: Sections 1-3 must be completed. Please print then sign and initial the form.

Section1: **PATIENT IDENTIFICATION**

Print Name: ___________________________
Street Address, city, State & Zip Code: ____
Patient's Social Security Number: ________________ Date of Birth: _____/_____/______

Section 2: **RIGHT TO REQUEST INFORMATION**

I understand I have the right to inspect or obtain a copy of my personal health information (PHI) maintained by __________________. I understand that __________________ will make every reasonable effort to provide me access to my protected health information. __________________ may provide a summary, in lieu of providing access to the protected health information requested, or may provide an explanation of the protected health information to which access has been provided, if I agree in advance to the summary, and if I agree in advance to the fees imposed for such summary. The fee for copying my protected health information includes the costs of supplies and labor for copying or for preparing an explanation, or summary, if agreed, and postage, if applicable.

Please initial all appropriate boxes:

___ Pursuant to that right, I hereby request __________________ to copy the following records and mail them to me at: ____

Description of records to be copied (include format request, e.g., paper copy or computer disk):

___ Pursuant to that right, I hereby request ____________________ to allow me to inspect my protected health information at the facility. I will contact the Unit Privacy Officer to arrange a mutually convenient time for inspection.

___ I agree to accept a summary of the PHI.

___ I agree to pay the costs associated with this request.

Section 3: **RIGHT OF DENIAL**

I understand ____________________ has the right to deny my request for access to the extent allowed by law. I also understand that ____________________ may deny my request for amendment if it is not in writing or does not include a reason to support the request.

____
Signature of Patient
(If under 18 years if age-Parent, Legal Guardian, or Legal Representative)

___ /___ /___
Date

If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1: __________________

FOR Missouri State USE ONLY

Date Received: ________________ By: _______________

Amendment has been: ☐GRANTED ☐DENIED

Comments:

If denied, letter of denial provide to patient per 8.030 paragraphs 4 and 5 on _________________________ (date)

Reason(s) for denial without right of review: (check all that apply)	**Reason for denial with right of review:**
☐Psychotherapy Notes	☐Reasonably likely to endanger life or physical safety of consumer/other person
☐Patient agreed to denial of access while in research project	☐Documentation makes reference to third party and granting access is likely to cause serious harm
☐Information for use in civil, criminal or administrative proceedings	☐Personal representative is requesting party, and consumer has been or may be subject to domestic violence/abuse/neglect
☐Information obtained from source other than facility under promise of confidentiality and access would identify the source	☐Other: e.g., failure to agree to pay fees for access
☐Other:	

Name and title of staff member processing request

____ ___ /___ /___

Signature of licensed health care provider Date

HIPAA Procedure 1.030, Form 1