

University Specialty Clinics, Department of Orthopaedic Surgery
Patient Request for Access to Health Information

As a patient of University Specialty Clinics, you are entitled under federal law to access your personal protected health information. In order to process your request for access to this information, please complete this form and submit it to the receptionist, who will forward it to the Department of Orthopaedic Surgery Privacy Contact person. When received by the Privacy Contact person, he or she will use the information to verify your identity and process your request.

Patient Name: _____ Birth date: _____

Date of access request: _____

I request access to the following protected health information: _____

(Describe information requested such as portion of the medical record and date.)

You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both. If you select "copy", please indicate your method of delivery.

I would like to view my protected health information. I would like to schedule an appointment to view my health information. I understand University Specialty Clinics may have a staff member sit down with me as I review my health information.

I would like a copy of my protected health information. I understand that I may be charged a fee of \$_____ for copying, including the cost of supplies for and labor of copying. I understand that I may be charged all applicable postage fees. I also understand that I may be required to pay the fee in full before I can obtain the copy. I have selected my delivery method below (if none is selected, I will pick up the copy):

I will return and pick up the copy when it is ready.

I would like the copy sent via U.S. mail to the following address:

If possible, I would like my copy sent to me using the following format

_____.

I understand that if University Specialty Clinics determines that an explanation or a summary of my requested health information is appropriate, I will be contacted by University Specialty Clinics for additional instructions.

I understand that University Specialty Clinics is given thirty days to process my request for access and that University Specialty Clinics may extend the deadline by an additional fifteen days if I am notified in writing of the extension.

By signing below, I acknowledge and agree to the above conditions.

Signature of Patient

OR

Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Description of Representative's Authorization to Sign for Patient

Tracking Form for Patient's Request for Access to Health Information

Access request on _____ by _____.

Access Request Reviewed by: _____

Request has been:

- Granted in full
- Granted in part
- Denied

Signature of Reviewer _____

Date _____

Letter indicating decision mailed to the patient on _____

If patient was given access in full, complete the information below:

The record was:

- Viewed by patient on _____. Name of staff member who assisted the patient in viewing his or her information _____.
- Copied on _____. Total cost for copies: \$_____.
- Picked up by patient on _____.
- Mailed via U.S. mail on _____.
- Sent to patient via _____ on _____.

Cost for postage: \$_____.

The fees were received in full by _____ on _____.

If decision was accepted in part, complete the information below:

If accepted in part, indicate which part(s) have been denied and the reason(s) why below:

Has patient asked for a review of the decision?

- Yes, letter asking for review received on _____.

Decision reviewed on _____ by _____.

Reviewing official's decision:

- Affirm decision
- Overturn decision (if overturned, complete the disclosure information above).

Patient notified of reviewing official's decision in letter sent on _____.

Comments of Licensed Healthcare Professional or Reviewer:

_____ Reviewing Official's Signature

_____ Date