COM-HPA-1020.01

Consumer Name: _____ ID#: _____

DOB: _____

ACCESS REQUEST FORM

Request to Review and/or Copy Health Information

You have the right to review and copy medical information that may be used to make decisions about your care. To review and copy your medical information, contact the Privacy Officer. If you request a copy of the information, you may receive one copy each year at no cost. For any additional copies during the same year, you may be charged a fee for the costs of copying, mailing, or other supplies associated with your request. Your request to review and copy your medical information may be denied in certain limited circumstances. If you are denied access to all, or any part, of your medical information, you may request that the denial be reviewed. Information regarding how to initiate the review process will be provided in writing at the time of any denial of access to your medical information.

You have a right to have an answer to your request within 30 days. If the information is not at this location, you have the right to have an answer within 60 days. If there are delays in getting you the answer, you will be told. The delay cannot be more than 30 days. You will receive an answer in writing.

Request to Review or/and Copy

I hereby request to ❑ Review ❑ Copy

The following information:

- ❑ Comprehensive Assessments
- ❑ Treatment Plan
- ❑ Consents
- ❑ Progress Notes for the period of time from _____ to _____.
- ❑ Discharge Summary
- ❑ Financial Records (payments, claims, authorizations)
- ❑ Other: _____

I understand there is specific health information to which this agency may deny access, without my having an opportunity for review, as follows:

- Psychotherapy Notes
- Information compiled for civil, criminal or administrative action or proceeding
- Health information subject to the Clinical Laboratory Improvement Amendments of 1988
- Records that are subject to the Privacy Act, 5U.S.C. 522a
- Health information obtained under a promise of confidentiality

I further understand there may be circumstances when a licensed health care professional may deny my request for access to my health information; and that I am allowed to request a review by another licensed health care professional.

_____

Consumer Signature **Title, If Legal Representative** **Phone #** **Date**

The requested information can be sent to the following:

Fax #: _____
OR
Consumer's Address:_____

Request determination continued on next page

Consumer Name: _____ ID#: _____
DOB: _____ Medicaid ID#: _____

This Section for Agency Use Only

Review of Request

Determination:	❑ **REQUEST APPROVED**
Agency Responsibilities:	❑ Determination of method for Consumer access ❑ Notice to Consumer of approved access ❑ Offer Consumer summary of information ❑ Notify Consumer of requirements for copies of health information
Determination:	❑ **REQUEST DENIED**
Reason for Denial:	❑ Reference made to another person could endanger that person ❑ Access could endanger life or physical safety of Consumer or other(s) ❑ Access requested by personal representative and access cause substantial harm to Consumer or other(s) ❑ Other_____
Agency Responsibilities:	❑ Written Notice to Consumer of basis for denial ❑ Provide Consumer with Opportunity to Request Review by licensed health care professional in Agency ❑ Provide Consumer with Opportunity to Request Record be sent to a physician or psychologist of his/her choice

_____ _____
Attending Physician/Agency Director or Designee Date

Request Denied-Second Review

Determination:	❑ **REQUEST APPROVED**
Agency Responsibilities:	❑ Determination of method for Consumer access ❑ Notice to Consumer of approved access ❑ Offer Consumer summary of information ❑ Notify Consumer of requirements for copies of health information
Determination:	❑ **REQUEST DENIED**
Reason for Denial:	❑ Reference made to another person could endanger that person ❑ Access could endanger life or physical safety of Consumer or other(s) ❑ Access requested by personal representative and access could cause substantial harm to Consumer or other(s) ❑ Other_____
Agency Responsibilities:	❑ Written Notice to Consumer of basis for denial ❑ Provide Consumer with contact information for US DHHS Secretary

_____ _____
Agency Licensed Health Care Professional Date