BAILEY MEDICAL CENTER

Request for Access to Patient's Health Information

As a patient of Bailey Medical Center, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it to the MANAGER OF RELEASE OF INFORMATION. When received by the MANAGER OF RELEASE OF INFORMATION, he or she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the MANAGER OF MEDICAL RECORDS, at 918-376-8140.

Patient Information: *Patient Name:* ____

Birth date: ________________ Patient Number: ________________ Date of access request: _____________

Information Requested
Please indicate specifically the information to which you are requesting access:

____

____

Access Method
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 have/will schedule(d) an appointment with Bailey Medical Center to view my health information on ______________________________________. I understand Bailey Medical Center 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 Bailey Medical Center may charge me a fee for the copies (including faxed copies. I have selected my delivery method below (if none is selected, I will pick up the copy at the practice):

[ ] I will return to Bailey Medical Center and pick up the copy when it is ready.

[ ] I would like Bailey Medical Center to send the copy via U.S. mail to the following address:

____
I understand that Bailey Medical Center may charge me all applicable postage fees.

[ ] I would like Bailey Medical Center to send the copy via facsimile to the following number: ____________________________

[ ] I would like my copy sent to me electronically via e-mail using the following e-mail address: _________________________

- **WARNING: I understand there is a level of risk that my PHI could be read or otherwise accessed by a third party while in transit and agree to receiving my PHI by unencrypted e-mail using the e-mail address above. My signature indicates I understand and accept the risk:____(Signature of patient)**

IF BAILEY MEDICAL CENTER CANNOT READILY PRODUCE THE INFORMATION IN THE FORM OR FORMAT YOU HAVE REQUESTED SUCH INFORMATION WILL BE MADE AVAILABLE TO YOU IN A READABLE HARD COPY FORM OR OTHER FORM OR FORMAT AGREED TO.

I understand that Bailey Medical Center is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that Bailey Medical Center may extend the deadline by an additional thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my medical record as compiled by Bailey Medical Center.

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

_______________	______________________________	__________________	_______________
(Date)	(Patient Signature)	(Parent/Guardian)	(Relationship to Patient)

FOR OFFICE USE ONLY

Form: Request for Access to PHI

Access request received on _________________ by ______________________.

Access Request Reviewed by: _______________________________________
Request has been:
[ ] Accepted in full [ ] Accepted in part [ ] Denied

________________________________ ______________________
Signature of Reviewer Date

Letter indicating decision mailed to patient on __________________.

If patient was given access <u>in full</u>, complete the information below:

The record was:
[ ] Viewed by patient on ____________. Staff member who assisted the patient in viewing his or her information was _________.
[ ] Copied on ___________________. Total cost for copies: $ ____________. Cost for postage/shipping: $ _____________.
- [ ] Picked up by patient on ____________________.
- [ ] Mailed via U.S. mail on ____________________.
- [ ] Sent to patient via _____________________ on ___________________.
- [ ] Faxed to patient at fax number on ____________________.

The fees were received in full by _________________________ on ___________________.

If decision was accepted <u>in part</u>, 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 (complete the disclosure information above).

Patient notified of reviewing official's decision in letter/fax sent on __________________.

If <u>denied</u>, complete the information below:
If denied, indicate why the request has been denied (be specific):
____

Has patient asked for a review of the decision?
[ ] Yes, letter asking for review received on __________________.

Decision reviewed on ___________________. Reviewing official: ______________________________

Reviewing official's decision:
[ ] Affirm decision [ ] Overturn decision (if overturned, complete the disclosure information above).

Patient notified of reviewing official's decision in letter/fax sent on __________________.

Comments of Healthcare Practitioner or Reviewer:
____

Reviewing Official's Signature____ Date ______________________________