

Request for Access to Protected Health Information

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME: _____
GROUP HEALTH PLAN ID NUMBER: _____
ADDRESS: _____
TELEPHONE NO.: _____

II. NATURE OF REQUEST FOR ACCESS:

- A. A. I wish : To inspect To have a copy of the following protected health information:
- My enrollment records
 - My payment records
 - My claims adjudication records
 - My case or medical management records
 - Any other protected health information used by my GROUP HEALTH PLAN ("GHP") to make medical decisions about me. Please describe: _____
- B. I wish to receive a copy of the requested protected health information in the following format:
- Photocopies
 - Electronic transmission (if available)
 - Other (if available) _____
- C. In lieu of inspecting or obtaining a copy of my protected health information, I would prefer to receive the requested information in the form of a summary prepared by my GHP at a cost to me of [\$_____]. Yes No
- The summary will describe _____.
- D. In addition to inspecting and/or obtaining a copy of my protected health information, I request that my GHP prepare an explanation of the requested protected health information at a cost to me of [\$_____]. Yes No
- E. I want you to mail the copies of my protected health information, a summary of my protected health information, and/or an explanation of my protected health information to the following address:
- _____
- _____

I understand that my GHP will charge me for the postage

III. CONDITIONS GOVERNING THE REQUEST FOR ACCESS:

- A. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), the GHP and its Business Associates are required to permit a individual to inspect and obtain a copy of his/her protected health information that GHP or its Business Associates maintain in a "designated record set." Under the Privacy Rule, a designated record set is a group of records maintained by the GHP and its Business Associates that are the medical records and billing records about individuals maintained by or for the GHP and any other records that may be used to make health care decisions about individuals.
- B. The individual is not, however, entitled to inspect or obtain a copy of any psychotherapy notes that GHP may have, any information GHP may have compiled in anticipation of or for use in any civil, criminal, or administrative proceeding, and certain other records, even if such records are in a designated record set.
- C. The individual will be charged \$0._____ per page for any copies made and a postage charge if copies are to be mailed to the individual. GHP will calculate the charge of the individual's request, and notify the individual of the amount due before GHP processes the request. If the individual chooses not to pay the charge, the request for access will be considered cancelled. There is no charge to the individual to inspect his/her records on GHP's premises.

SIGNATURE: _____ **DATE:** _____

If this request is by a personal representative on behalf of the individual, complete the following:

PERSONAL REPRESENTATIVE'S NAME: _____

RELATIONSHIP TO THE INDIVIDUAL: _____

GHP/BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

Response to Request for Access

GHP must respond to an access request within 30 days of its receipt, unless the requested records are off site. GHP then has 60 days to respond.

Date access request received: ____/____/____

Date appropriate GHP units and business associates directed to search for requested records:
____/____/____

GHP may take one 30-day extension by notifying the individual in writing within the 30 or 60-day response period of the reason for the extension and the date on which GHP will provide its response:

Extension notice sent on: ____/____/____

Response date promised in extension notice: ____/____/____

Reason given for extension:

Review of Request for Access

The request for access has been reviewed by GHP/Business Associate and is:

Accepted Denied

Denial of Request for Access

If denied, is the denial for one of the following unreviewable reasons for denial:

- Protected health information is not part of the designated record set.
- The requested information is not maintained by GHP or its Business Associate(s).
- Federal law forbids making the requested information available to the individual 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 in which GHP is involved.
- The requested information was obtained from someone other than a health care provider 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.

If denied, is the denial for one of the following *reviewable* reasons for denial:

- A licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others.
- A licensed health care provider has determined that the requested information identifies a third person who is not a health care provider and that substantial harm is reasonably likely to occur if access to the information is granted.
- A licensed health care provider has determined that access to the requested information by the individual's legal representative could result in harm to the individual.

Review of A Denial of Request for Access

Individual requested a review of GHP's denial of access on: ____/____/____.

A licensed health care professional examined the individual's request for review of a denial of access on: ____/____/____.

Result of the review is attached. __ Yes __ No

Request for Access Granted

Access granted on ____/____/____ and notice of granted request for access sent to individual.

- Records inspected: ____/____/____
- Copies supplied: ____/____/____ Charges: \$_____ Paid: ____/____/____
- Summary or explanation provided: ____/____/____ Charges: \$_____ Paid: ____/____/____

Signature of GHP/Business Associate Representative: _____

Date: _____