

REQUEST TO ACCESS THE MEDICAL RECORD

Patient Name: _____

Patient DOB: _____ Account Number: _____

Date of request: _____

Request is to: Review the medical record _____

Receive copies of the medical record _____

(if checked-have patient complete authorization to disclose information form)

If viewing the chart, I request the following day and time: _____

If receiving copies, I request them to be in paper format: _____ Other: (specify) _____

Signature: _____

For Office Use:

Disposition of request: Granted: _____ Date records provided or chart reviewed _____

Denied: _____ Reason: _____

If denied, patient must receive a written notice of the reason- copy of letter attached: Yes _____

Did the person request a review of the denial? No _____ Yes _____

If review requested, describe outcome: _____

Signature: _____

* Completed form to be filed in the patient's chart

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Name: _____

Patient DOB: _____ Account number: _____

Date of request: _____

Request for disclosures for the time period of : _____

Signature _____

For office use:

Date disclosure was provided to patient _____

Charge to patient (if applicable) _____

Signature _____

*Completed form to be filed in patient's chart

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name _____

Patient DOB: _____ Account Number: _____

Date of request: _____

Choose the appropriate description of your request:

I request communications regarding my protected health information to be in the form of (specify):

I request that communications regarding my protected health information be sent to this alternative address:

Signature: _____

For office use:

Disposition: Granted _____ Denied _____

If granted, was memo screen created with the appropriate information? Yes _____

was HIPAA alert sticker with notation placed on chart? Yes _____

If denied, patient must receive a written notice of the reason- copy of letter attached : Yes _____

Signature: _____ Date: _____

*Completed form to be filed in patient's chart

REQUEST TO RESTRICT USE AND DISCLOSURE

Patient Name: _____

Patient DOB: _____ Account Number: _____

Date of request: _____

I request that the following restriction be placed on the use and disclosure of my Protected Health Information: _____

This restriction is required for the following reason: _____

Signature: _____

For office use

Disposition of request: Granted _____ Denied: _____

If denied, the patient must receive a written notice of the reason-copy of letter attached: Yes _____

If granted, was a memo screen created with the restriction noted? Yes _____

was a HIPAA alert sticker with notation of restriction placed on chart? Yes _____

Signature: _____ Date of Initiation: _____

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient DOB: _____ Account Number: _____

Date of request: _____

I request that the following chart notation be amended: *Must specify date and specific wording in question:*

It is my belief that the note is in error because: _____

I understand that I have a right to disagree should the decision be made not to change the records in question and that disagreement must be made in writing: Yes _____ *please initial here*

Signature: _____

For office use

Disposition of request: Granted: _____ Denied: _____

If denied, patient must receive a written notice of the reason- copy of letter attached : Yes _____

Did the patient submit a letter disagreeing with the decision? No _____ Yes _____

If yes, the physician may respond in writing to the patient regarding the letter of disagreement (*attach if applicable*) and the denial will be reviewed by another health care provider.

Name of Reviewer: _____ Date of Review: _____

Title of Reviewer: _____

Disposition: Denial upheld _____ Decision reversed- note to be amended _____

The decision of the reviewer must be communicated to the patient in writing-copy of letter attached _____

If the request to amend is granted-the appropriate changes should be made and the patient should be notified in writing to include a request for the names and addresses of any persons he wishes to be notified of the amendment- copy of letter attached Yes _____

*All documentation should be filed in the patient's chart attached to the page of the note in question