

OVERLAKE ARTHRITIS AND OSTEOPOROSIS CENTER
Request for Access to PHI (Protected Health Information)

Patient Name: _____ Patient ID #: _____

I hereby request **OVERLAKE ARTHRITIS AND OSTEOPOROSIS CENTER** to allow me to inspect and/or obtain a copy of the following records:

Description of records to be inspected/copied: _____

And I understand that I can inspect my records free of charge. However, if I wish to obtain copies of the records or have the copies mailed to me, there is a nominal fee associated with the request which is:

Calculated fee for copying: _____ Calculated fee for mailing: _____

which covers the cost of copying and mailing the aforementioned records. I also understand that I may be required to pay the fee in full before I can obtain the copies. The aforementioned records can be mailed to me at the following address:

Address1: _____ Home Phone: _____

Address2: _____ Work Phone: _____

City/State/Zip: _____

I further understand that:

- 1) All healthcare providers, including **OVERLAKE ARTHRITIS AND OSTEOPOROSIS CENTER**, maintain certain protected health information about me as a patient, such as medical and billing records, and records that are used, in whole or in part, to make decisions about me, my treatment, or billing for services rendered.
- 2) I have the right to inspect and obtain a copy of my above mentioned protected health information maintained by **OVERLAKE ARTHRITIS AND OSTEOPOROSIS CENTER**.
- 3) My request must be made in writing using this form, which must be completed prior to **OVERLAKE ARTHRITIS AND OSTEOPOROSIS CENTER** providing me with the requested information.
- 4) If I request **OVERLAKE ARTHRITIS AND OSTEOPOROSIS CENTER** to copy and mail the requested information, they have the right to charge me for copying and mailing the requested information to me.
- 5) I have the right to request an amendment to my protected health information mentioned above.
- 6) Within 30 days (60 days if information is not maintained or accessible on-site), I will receive a response from **OVERLAKE ARTHRITIS AND OSTEOPOROSIS CENTER** indicating whether my request for access has been accepted or denied, or a notification that they require an additional 30 days to consider my request. If they require an extension, they will explain the reason for the delay and the date by which they will make a decision. If they deny my request, they will inform me in writing of the reason for the denial, and instruct me on how I can go about disputing a denial or filing a complaint.

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- Parent or guardian of unemancipated minor
 Court appointed guardian
 Executor or administrator of decedent's estate
 Power of Attorney

Request Accepted Denied

FOR OFFICE USE ONLY

Reason for Denial (if applicable)

- Access is likely to endanger the life or physical safety of the individual or another person
 Psychotherapy notes
 The information is compiled for use in a civil, criminal, or administrative action or proceeding
 Other (full list of other reasons for possible denial at 45 CFR §164.524(a)(1)-(3)):

Date Request Received _____

Received By _____

Date Request Fulfilled _____

Fulfilled By _____

Extension Requested ____ Yes ____ No

Date Patient Notified in Writing of Extension _____

If Extension Requested, Give Reason _____