School of Medicine
University Specialty Clinic
Division of Pulmonary, Critical Care and Sleep Medicine

Patient Request for Access to Health Information

As a patient of University Specialty Clinics, you are entitled under federal law to access your personal protected health information. In order to process your request for access to this information, please complete this form and submit it to the receptionist, who will forward it to the Privacy Contact person. When received by the Privacy Contact person, he or she will use the information to verify your identity and process your request.

Patient Name: _____ Date of Birth: _____

Date of access request: _____

I request the following protected health information: _____

_____

(Describe information requested such as portion of the medical record and date.)

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 would like to schedule an appointment to view my health information. I understand University Specialty Clinics 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 I may be charged a handling fee of $25 and $.65 for each page - up to 30 pages and all additional pages are $.50 each. I understand that I may be charged all applicable postage fees. I also understand that I may be required to pay the fee in full before I can obtain the copy. I have selected my delivery method below:

_____ I will return and pick up the copy when it is ready

_____ I would like the copy sent via U.S. mail to the following address:

_____

_____

_____

_____

I understand that if the University Specialty Clinics determines that an explanation or a summary of my requested health information is appropriate, I will be contacted by University Specialty Clinics for additional instructions.

I understand that University Specialty Clinics is given thirty days to process my request for access and that University Specialty Clinics may extend the deadline by an additional fifteen days if I am notified in writing of the extension.

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

_____ OR _____
Signature of Patient Signature of Patient's Representative

_____ _____
Date Printed Name of Patient's Representative

_____
Description of Authorization to Sign for Patient