Request for Access to Protected Health Information

Texas Health Medical Associates®

Section A: Please complete the following information for all requests

Patient Name: _____ Account Number:

Address: _____ _____

Street: _____ Date of Birth: ____/____/____

City: _____ State: _____ Zip: _____ Today's Date: ____/____/____

I hereby request that Texas Health Medical Associates provide me with (please check all boxes that apply)

☐ Access to ☐ My own copy of the "Requested Information" checked below:

☐ My medical records.

☐ My billing records.

☐ Any other records used by AdventHealth to make medical, billing or other decisions about me. Please describe:

_____

☐ I am only interested in accessing or obtaining a copy of the Requested Information relating to the time period

____/____/____ through ____/____/____

☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by Texas Health Medical Associates.

☐ I would prefer to receive the Requested Information in the form of a summary if available as prepared by Texas Health Medical Associates at a cost to me of ($_____).

☐ Other specific requests: _____

7. What format do you wish to receive the information in:

☐ Photocopies ☐ Electronic (if available) ☐ Other (if available) _____

Signature of patient or legal representative: _____ Date: ____/____/____

Printed name of personal representative: _____

Relationship to Patient: _____

Texas Health Medical Associates®

Section B: Must be completed by AdventHealth only.

Access has been: ☐ **Accepted** ☐ **Denied**

If denied, check the reason for denial

☐ PHI is not part of your designated record set.

☐ Federal law forbids making the PHI in question available to you for inspection (e.g., Privacy Act of 1974).

☐ PHI is in the form of psychotherapy notes.

☐ PHI has been compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

☐ PHI was obtained under promise of confidentiality and access would be reasonably likely to reveal source of PHI.

☐ PHI is temporarily unavailable because you have agreed to denial of access in connection with your agreement to participate in a research study.

☐ Licensed health care professional determined access to PHI is reasonably likely to physically harm you or others.

☐ Licensed health care professional determined PHI identifies a third person who is reasonably likely to be substantially physically, emotionally, or psychologically harmed if access to PHI is granted.

☐ Licensed health care professional determined providing your personal representative access to PHI is reasonably likely to harm you.

☐ We are acting under the direction of a correctional institution and allowing the inmate (you) to obtain a copy of PHI would jeopardize the health, safety, security, custody or rehabilitation of you or another person at the correctional institution.

☐ PHI is not maintained by our health care facility.

☐ We do not know who maintains the PHI you requested.

☐ We reasonably believe the PHI you requested is maintained by (Contact Information):

_____

_____

Right to Review

☐ You do not have the right to a review of this denial.

☐ You do have the right to a review of this denial.

Contact Information:

_____

_____

☐ You do have a right to complain to the Secretary of the Department of Health and Human Services. Please see enclosed information.

Texas Health Medical Associates®

Staff comments: _____

_____

_____

Signature of staff person: _____ Date: ____/____/____

Print name and title: _____

You may be charged a cost-based fee for labor, supplies, any portable electronic media used and postage.