# PATIENT REQUEST FOR ACCESS TO PHI

This form is used to make a request to inspect and/or obtain copies of protected health information maintained by Health Claims Plus on behalf of _____.

Please read the following and complete the information requested:

You have the right to access, inspect and obtain a copy of your protected health information maintained by the above indicated EMS provider for as long as HCP &/or EMS provider maintains the PHI. To inspect or copy PHI about you, you must send a written request to the "**Records Coordinator**" whose name appears at the end of this notice. We may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to fulfill your request. We may deny your request to access, inspect and copy in certain circumstances. Patients are not entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records. If you are denied access to PHI about you, you may request that the denial be reviewed. All determinations will be provided to you in writing within 60 days of your request.

Please type or print neatly; we will not process incomplete or illegible forms.

**INDIVIDUAL REQUESTING ACCESS**

Last Name: _____ First Name: _____ MI: _____

**PATIENT'S INFORMATION:**
Last Name: _____ First Name: _____ MI: _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Phone: (home) _____ (work) _____
Date of Birth: ____/____/_____

The description of the specific protected health information to be accessed (e.g., complete (ambulance) medical record, ED records, billing records, radiology reports. Please include dates of service):
_____
_____
_____
_____

____ I want a summary or an explanation of these records (I understand **HEALTH CLAIMS PLUS** may charge copies or printouts. I will be contacted by **HEALTH CLAIMS PLUS** on behalf of the above mentioned EMS provider with an estimate of charges prior to the completion of any request.)

*Continued on next page*

____I want a copy/printout of the full medical record records (I understand **HEALTH CLAIMS PLUS** may charge copies or printouts. I will be contacted by **HEALTH CLAIMS PLUS** on behalf of above named EMS provider with an estimate of charges prior to the completion of any request.)

____I want to pick up the records. . (I understand I will be contacted by **Health Claims Plus** to be notified of when the records will be ready to be picked up should my request be approved)

____I want the records mailed to me records (I understand **HEALTH CLAIMS PLUS** may charge for mailing out of records. I will be contacted by **HEALTH CLAIMS PLUS** on behalf of the above named EMS provider with an estimate of charges prior to the completion of any request.)

____I want to inspect these records on site. (I understand I will be contacted by **Health Claims Plus** to establish a mutually agreeable time should my request be approved)

Signature _____ Date_____

Please send to
**Health Claims Plus**
**Medical Records Department**
**2800 Beaumont Ave. Suite E**
**Liberty, TX 77575**

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OFFICE USE ONLY

Request _____ GRANTED _____ DENIED

Access Type _____ HARD COPIES CHARGES _____ Pt notified on _____

_____ ELECTRONIC ACCESS

Patient to _____ PICK UP Patient to pick up on or after _____

_____ MAILING REQUESTED Mailing charges _____ Pt notified on _____

_____ ACCESS ON SITE Arranged date for access _____

Location arranged _____

**CONFIDENTIAL**