HEALTH INFORMATION ACCESS REQUEST FORM

Under the Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to access, inspect and/or obtain a copy of your health information maintained in our designated record set. Usually, this includes medical and billing records. The information requested in this form is needed to comply with those Privacy Rule requirements. Your request to access, inspect, and/or obtain a copy may be denied in limited circumstances. If your request is denied, you will receive a written statement indicating the reasons for denial.

Personally identifiable information requested in this form is mandatory in order to process your request and will only be used for this purpose.

Instructions: Please return this form to this address, or, call this number with questions:

Michelle Haider
Vital Tears HIPAA Privacy Officer
mhaider@saving-sight.org
10560 N. Ambassador Dr. Suite 210
Kansas City, MO 64153
(816) 255-1387

Section A: Individual Requesting Access

Name (Last, first, middle initial):

_____

Address (Street, City, State, and Zip Code):

_____

_____

_____

Telephone: (_____)_____ E-mail:_____

☐ Check this box if you want your health information records mailed to a different address. If so, complete the information below.

Address – Street, City, State, and Zip Code:

_____

_____

_____

Section B: Protected Health Information Access Requested

Please specify the information to which you are requesting access:

Please indicate the form or format in which you would like to receive your requested information:

Please indicate the timeframe of the records to be inspected or copied:

Please indicate the means by which you wish to inspect or obtain a copy of the requested information (fax, mail, on-site, e-mail, etc.), and provide the necessary phone number or address:

We may impose a fee of $_____ to cover the cost of copying the requested information or postage when you have requested a copy of the information be mailed to you.

Do you agree to these fees? _____ YES _____ NO

Section C: Signatures

Patient Name

Patient Account Number

Signature

Date and Time

If this request is from a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Name of Personal Representative

Relationship to Patient

Signature of Personal Representative

Date and Time

For Vital Tears Use Only:

Date Received: _____ _____ Accepted _____ Denied

Date and Time of Inspection: _____

If denied, check reason for denial:

_____ Excepted Information _____ Inmate Request _____ Confidentiality Issues

_____ Research _____ Privacy Laws _____ Other: _____

Date and method of informing individual of original decision: _____