FALLING WATERS

Request for Access to PHI (Protected Health Information)

Patient Name: ____ **Patient DOB:** ____________________

Best Daytime Ph #: _______________

1. I hereby request Falling Waters to allow me to inspect and/or obtain a copy of the following records:

2. Description of records to be: ❐Inspected or ❐Copied: ____

3. Date range of records to be: ❐Inspected or ❐Copied: ____

4. Case Type that records are being requested from: ❐General Insurance/Cash ❐Auto Injury ❐Work Injury

5. Provider Type records will come from: ❐Doctor of Chiropractic ❐Physical Therapist ❐Other: ___________

6. 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/faxing: $ 0.10 per page **Calculated fee for mailing: Cost of postage**

This fee covers the cost of copying/faxing 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 given to me via method chosen below:

❐ Paperwork to be picked up in person **(No postage fee)**

❐ Fax #: ____ **(No postage fee)**

❐ Mail: Address: _________________________________ **(Postage fee applicable)**

____

City/State/Zip:____________________________________

7. I further understand that:

1) All healthcare providers, including Falling Waters, 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 Falling Waters.
3) My request must be made in writing using this form, which must be completed prior to Falling Waters providing me with the requested information.
4) If I request Falling Waters 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. Within 30 days (60 days if information is not maintained or accessible on-site), I will receive a response from Falling Waters 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.

____

Printed Name of Patient or Legal Representative

____

Signature of Patient or Legal Representative

____

Date

Relationship to Patient (*if applicable*)

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

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FOR OFFICE USE ONLY

FRONT DESK: If applicable*:* If Request is applicable to reasons below then request is denied: Check Reason for Denial

☐ Access is likely to endanger the life or physical safety of the individual or another person
☐ Psychotherapy notes ☐ The info 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)*):

Request is: ☐ Accepted ☐ Denied

If Request Accepted: ☐ No blank info above
☐ Date Request Received: ____________ ☐ Received By: ________________________________ ☐ File in RR Bin

RECORDS REQ DEP: ☐ Complete Patient Records Request Log and Worksheet

12/19/2022