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**" at the address listed 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 verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking for information necessary to verify that the requestor has the right to access PHI. We may deny your request to access, inspect and copy in certain circumstances. Patients arenot 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 or RECORDS:

Last Name:_____First Name:_____MI: _____

PATIENT'S INFORMATION:
Last Name:_____First Name:_____MI: _____
Address:_____Apt #: _____
City:_____State:_____Zip: _____
Phone: (home) _____ (work) _____
Social Security #: _____
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.)

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____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)

____This request is regarding a *deceased patient*. I understand that I must submit pertinent documents such as copies of a will, a medical power of attorney that remains in effect after patient's death, or other papers that support my position as executor or personal representative.

Signature_____Date_____

*A copy of the requestor's driver license must be submitted with this form.

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

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 _____