



805 S. Oakland
St. Johns. MI 48879

Individual Request for Access to Protected Health Information

Patient's Name: _____

Birth date: _____

Address: _____

Phone No.: _____

Social Security Number: _____

As provided by the Health Insurance Portability and Accountability Act (HIPAA) and applicable Michigan law, you have a right of access to inspect and obtain a copy of your health information contained in a designated record set. This right does not apply to:

1. Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
2. Protected health information which is:
 - a. Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 USC 263a, to the extent the provision of access to you would be prohibited by law; or
 - b. Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

As further provided by HIPAA and Michigan law, under certain circumstances Clinton Memorial Hospital may deny patient (or other requestor) access to certain protected health information.

Specific type of information to which you request access:

Date(s) of service: _____

Type(s) of service: _____

Description of information: _____

Clinton Memorial Hospital will act on this request within 7 business days of the date listed above or, within 60 days if the requested information is not maintained or accessible to Clinton Memorial Hospital on-site. Such action will either inform you of the acceptance of the request and provide you with the requested access or provide a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed under applicable law.

If the requested information is contained in more than one designated record set or at more than one location, and access is granted, Clinton Memorial Hospital needs only to provide you with access to the requested information contained in one of the designated record sets.

Indicate the format in which you would like to receive your requested information. Paper copy Computer disk

Do you agree to receive a summary of the requested information in lieu of access? Yes No

Indicate the means by which you wish to inspect or obtain a copy of the requested information and provide the necessary address or phone numbers at which you can be contacted. Fax Mail On-site inspection

Address: _____

Phone number: _____ Fax number: _____

If Clinton Memorial Hospital cannot readily produce the information in the format you have requested, such information will be made available to you in a readable hard copy format or other format that you agree to.

Clinton Memorial Hospital may impose a fee of [] to cover the cost of labor, copying, postage, and preparing a summary of the requested information. Do you agree to such fees imposed by Clinton Memorial Hospital for providing a copy or summary of the requested information? Yes No

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If you do not agree to the fee(s), you may withdraw your request or modify your request to reduce the fee.

Printed name of patient or patient's representative

Signature of patient or patient's representative

Date

Complete only if patient or representative signs by use of a mark:

Printed name of witness

Signature of witness

Date

Printed name of witness

Signature of witness

Date

[If the above signature is that of a patient's representative, Clinton must complete the following.]

Clinton Memorial Hospital has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____ (description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by (Associate name and signature)

Date

REVIEW SECTION: (This section is to be completed by the reviewer)

Reviewer's Decision: Grant the Access Request

Deny the Access Request

Date received:	Reviewed by:
Department Director:	Review Date:

Reviewer's Comments:

Reviewer's signature

Date

If your request for access to protected health information has been denied, you may have the right to request a reconsideration of the denial decision. You must submit your request for reconsideration in writing to Clinton Memorial Hospital at the address on the top of this form. You may obtain a *Request for Reconsideration of Denial of Access to Protected Health Information* form by calling _____.

NOTE: As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to complain about our privacy policies, procedures or actions. Sparrow Health System will not engage in any discriminatory or other retaliatory behavior against you because of your complaint. All complaints must be submitted in writing to the Chief Privacy Officer at the address on the top of this form. A complaint form is available from the Chief Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services.