SALUS

REQUEST FOR INSPECTION OR ACCESS TO PERSONAL HEALTH INFORMATION

Purpose: This form is used for a patient to request to inspect or obtain a copy of his/her information in a designated record set that we maintain or that our business associates maintain for us.

SECTION A: Patient Information.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Medical record number: _____

SECTION B: Recipient of requested materials/information (if recipient is not the patient or personal representative).

Name: _____

Address: _____

Telephone: _____ E-mail: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

You have the right to inspect and obtain a copy of your information contained in a designated record sets. You are not entitled to obtain a copy of any information we may have compiled in anticipation of or for use in a civil, criminal or administrative proceeding, and certain other records. To exercise your right of inspection or access, please complete Section C. This request is valid for 60 days after you sign it.

SECTION C: Protected health information access requested.

Please specify the records to which you wish to have access:

( ) Medical record ___ copy ___ Original	( ) Medical visits. Specify dates: _____
( ) Dental record	( ) Pathologic report
( ) Progress Notes	( ) Psychology
( ) radiology reports and images	( ) Drugs Prescriptions
( ) Laboratory results	( ) Other

You understand that information in your medical record might include information regarding sexual transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS) or infection with the immunodeficiency virus. Disclosures of PHI to entities not covered by HIPAA are not protected by local and federal privacy laws.

Do you wish to: ( ) Inspect the record? ( ) Obtain a copy of the record?
Would you like us to make the records available to you: ( ) On paper? ( ) Electronically?

Do you want us to send the documents by fax? Please indicate fax number: _____

Do you want us to: ( ) Mail the copies? ( ) e-mail the copies?*

Please indicate the name and address of the person you are interested in having access to and a copy of the information

_____ _____

_____ _____

_____

PATIENT SIGNATURE.

_____ Date: _____

If this request is by a personal representative on behalf of the patient, complete the following:

REPRESENTATIVE SIGNATURE

_____ Date: _____

Personal Representative's Name (must present evidence): _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

*** If you request it, we will honor your request to send electronic copies via unsecured email to the email address you provided on this request form. By law, we must notify you that there is some level of risk in using unsecured email. For example:**

- **The email may be stored by the Internet Service Providers who provide transport of electronic mail**
- **Your email service provider has access to your stored emails**
- **We may send the e-mail to an incorrect address**
- **A hacker or other unauthorized individual could use technical means to access the email**
- **Once the email is received by you it may become vulnerable to unauthorized exposure.**