Request for Access to Patient's Protected Health Information

As a patient, guardian or personal representative of a patient of Signature Psychiatric Hospital, you are entitled under Federal law to access your personal protected health information (PHI) or protected health information (PHI) of the patient maintained in a "designated record set." You also have the right to access electronic PHI, when such PHI is stored electronically.

In order to process your request for access to this information, please complete this form and submit it to the Health Information Services Department. When received, correspondence staff will use the information to verify your identity and process your request. **State law requires physician approval on release of Protected Health Information.** If you have any questions or concerns, please contact Health Information Services at (816) 691-5108.

Patient Information Date of request: ______________

Patient Name: __________________________________ Birth date: _________________

SSN: _________________________ Dates of Service: ______________________

Requester Information

Requester Name: ________________________________

Current Address: _________________________________ ____________________________

(Street) (City/Sate/Zip)

Current Phone #: ______ _____________________

(Area Code)

Current Fax#: ______ _____________________

(Area Code)

Information Requested

Please indicate specifically the information to which you are requesting access:

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Please provide reason for the request:

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Access Method

You have the right to view your/your child's protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both. If you select "copy", please indicate your method of delivery.

[ ] I would like to **view** my/my child's protected health information. I have/will schedule(d) an appointment with Signature Psychiatric Hospital to view my/my child's health information on _______________. I understand Signature Psychiatric Hospital will have a staff member sit down with me as I review my/my child's health information.

[ ] I would like a **copy** of my/my child's protected health information. I understand that Signature Psychiatric Hospital may charge me a fee for the copies (including faxed copies) **according to relevant state law**. I also understand that I may be required to pay the fee in full before I can obtain the copy. I have selected my delivery method below (if none is selected, I will pick up the copy at the hospital):

[ ] I will return to Signature Psychiatric Hospital and pick up the copy when it is ready.

[ ] I would like Signature Psychiatric Hospital to send the copy via U.S. mail to the following address:

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I understand that Signature Psychiatric Hospital may charge me all applicable postage fees.

[ ] I would like Signature Psychiatric Hospital to send the copy via facsimile to the following number: ________________________.

[ ] I would like electronic copies, where electronic copies are readily producible. If you would like such copies sent to you via encrypted email, indicate your email address:

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[ ] I would like Signature Psychiatric Hospital to provide to me an explanation or summary of the information provided. I understand that Signature Psychiatric Hospital may charge me a fee of $ _____ for the explanation or summary, and I may be required to pay the fee in full before I can obtain the explanation or summary.

I understand that Signature Psychiatric Hospital is given **thirty days** to process my request for access if my/my child's information is maintained on-site, **sixty days** if the information is maintained off-site, and that Signature Psychiatric Hospital may extend the deadline by an additional **thirty** days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my/my child's medical record as compiled by Signature Psychiatric Hospital.

By signing below, I acknowledge and agree to the above conditions.

____ ____________________

Patient Signature Date

____ ____________________

Parent/Guardian Signature (Relationship to Patient) Date