



Town of Chilhowie Fire Department Standard Operations Manual

Form 604.02

Issue Date: 07/10

HIPAA Patient Access Form

Revision Date: 04/12-02

PURPOSE:

Patients form for requesting access to protected health information.

INDIVIDUAL RESPONSIBLE FOR COMPLETING:

Patient requesting access to protected health information.

WHEN FORM IS TO BE COMPLETED:

At the time access is requested.

INSTRUCTIONS FOR COMPLETING:

The patient will complete and sign the form.

ROUTING:

Completed forms will be directed to the HIPAA Privacy Officer.

RETENTION:

The completed form will be retained with the PPCR.

COPIES TO:

No additional copies required.



TOWN OF CHILHOWIE FIRE DEPARTMENT

HIPAA Patient Request for Access Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years prior to the date of the request from the Town of Chilhowie Fire Department, to amend your PHI and to request restrictions on the uses and disclosures of your PHI. The Town of Chilhowie Fire Department is not required to agree to any restrictions requested by the patient; however any restrictions agreed to by the Town of Chilhowie Fire Department are binding on the Town of Chilhowie Fire Department.

Please indicate your use of this form:

- Access/Review of information
- Copied information
- Access or Review/Request for Amendment followed
- Access or Review/Request for Accounting followed
- Access or Review/Request for Restrictions followed

Signature _____ Request Date _____