Effective date: April 14, 2003

NORTHEAST WYOMING PEDIATRIC ASSOCIATES, P. C.
Request to Copy Patient's Health Information

As a patient of you are entitled under federal law to access your Protected Health Information (PHI) maintained in a "designated record set." In order to process your request to copy this information please complete this form and submit it to the Privacy Officer. When received by the Privacy Officer, he or she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer at Northeast Wyoming Pediatric Associates, P. C., 916 Jackson Avenue, Sheridan, WY 82801. ***Failure to complete this form in its entirety may result in a denial, or a delay***.

Patient Information

Patient Name(s): ____ Birth Date(s): ________________________________

____ ________________________________

EID (Office use only): ___________________________

You have the right to copy your Protected Health Information. Also please indicate your method of delivery.

I understand that Northeast Wyoming Pediatric Associates, P. C. may charge me a fee for the copies as set forth in the following schedule $_____ for research and retrieval, $0.50 per page for copying. 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, others are available upon request (if none is selected, I will pick up the copy at the practice).:

[ ] I will return to Northeast Wyoming Pediatric Associates, P. C. and pick up the copy when it is ready.

[ ] I would like Northeast Wyoming Pediatric Associates, P. C. to send the copy via U.S. mail to the following address:

____

I understand that Northeast Wyoming Pediatric Associates, P. C. may charge me for all applicable postage fees.

[ ] I would like Northeast Wyoming Pediatric Associates, P. C. to send the copy via facsimile to the following number: _________________________. I understand that Northeast Wyoming Pediatric Associates, P. C. may charge me a fee of $1.00 per faxed page.

Please specify what parts of the record are requested:

Summary (check if desired)

[ ] I would like Northeast Wyoming Pediatric Associates, P. C. to provide to me an explanation or summary of the information provided. I understand that Northeast Wyoming Pediatric Associates, P. C. may charge me a fee of $35.00 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 Northeast Wyoming Pediatric Associates, P. C. is given **thirty days** to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that Northeast Wyoming Pediatric Associates, P. C., may extend the deadline by and 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 "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.
By signing below, I acknowledge and agree to the above conditions.

____ ______________________________________
Signature of Patient, patient's parent, guardian or representative Date of request

Printed Name of patient, parent, guardian or representative:_________________________________

Phone #: ___________________________________ Relationship to Patient: _______________________

Patient Name: ____ Patient ID: ________________

FOR OFFICE USE ONLY

Access request received on ____________________ by ____.

Access request reviewed by: ____.
Request has been:
[ ] Accepted in full
[ ] Accepted in part
[ ]Denied

____ __________________________________
Signature of Reviewer Date

Letter indicating decision mailed to patient on ____.

If access was granted <u>in full</u>, complete the information below:

Printed / Copied on ______________________. Total cost for copies: $__________________________.
[ ] Picked up by patient on _______________________________.
[ ] Mailed via U.S. mail on _______________________________.
[ ] Sent to patient via ____________________________________.
[ ] Faxed to patient at fax number on ________________________.
Cost for postage /shipping: $ ________________________.

The fees were received in full by _______________________________________ on ___________________.

If decision was accepted <u>in part,</u> complete the information below:

If accepted in part, indicate which part(s) have been denied and the reasons(s) why below:
____
____
____

Has patient asked for a review of the decision?
[ ] Yes, letter asking for review received on ______________________________.

Decision reviewed on ______________________________ by ______________________________________.

Reviewing official's decision:
[ ] Affirm decision [ ] Overturn decision (complete the disclosure information above).

Patient notified of reviewing official's decision in a letter/fax sent on ___________________________.

Patient Name: ______________________________ Patient ID: ________________

If denied, complete the information below:

If denied, indicate why the request has been denied (be specific):

____

____

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____.

Has patient asked for a review of the decision?

[ ] Yes, letter asking for review received on ______________________________.

Decision reviewed on _______________________________________.

Reviewing official: ____.

Reviewing official's decision:

[ ]Affirm decision:

[ ] Overturn decision (if overturned, complete the disclosure information above).

Patient notified of reviewing official's decision in letter/fax sent on ___________________________________.

Comments of Healthcare Practitioner or Reviewer:

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____ ____________________________________

Reviewing Official's Signature Date