



REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LEGAL DIVISION

SFN 1979 (9-2022)

You (or your legal representative) have the right to request access to your protected health information (PHI) maintained by a Department of Health and Human Services (Department) health plan, health care facility, or program providing health care. A separate request must be made to each Department health plan, health care facility, or program providing health care. If your request is not to a Department health care provider, health plan, or program providing health care, please utilize SFN 1982 Request to Access Records and Information Non-Protected Health Information (Non-PHI).

The Department will respond to your request within 30 days from the receipt of your request. In limited circumstances, you may be denied access to all or part of your PHI. If you are denied access to all or part of your PHI, you will be notified in writing the reason for the denial, if you have a right to have the denial reviewed, and how to request a review. The Department may determine that your PHI contains certain information that requires an explanation from a Department staff member in order to be accurately understood. If you refuse this explanation you will be asked to sign a statement indicating your refusal.

You have the right to receive your PHI in the form and format that you request. If the Department cannot produce it in that form or format, the PHI will be provided in a readable hard copy form or another form or format that you and the Department agree to. The Department may charge you a fee for providing you with copies of your PHI or a written summary of your PHI, and may require fees be paid in advance. The Department may verify the identity and authority of the person requesting access to PHI.

CLIENT INFORMATION

Client Name (Last, First, Middle Initial)		Date of Birth	
Previous Names Used			
Address	City	State	ZIP Code
Name of the Department Health Plan, Health Care Facility, or Program Providing Health Care			
Telephone Number (if we have questions regarding your request)			

ACCESS AND INFORMATION

Type of Access (check only one) <input type="checkbox"/> Obtain Copies of PHI <input type="checkbox"/> Obtain Written Summary of PHI <input type="checkbox"/> View PHI	Dates of PHI Associated with Your Request From: _____ To: _____
Specify the PHI Below (be as specific as possible)	

FORMAT AND DELIVERY METHOD:

PHI may be viewed during normal working hours by appointment. A Department representative will be present during your review to answer any questions you may have. PHI may not be removed from the Department premises, however, you may request copies (fees may apply).

PHI not picked up within 10 days from date of notification will be destroyed and a new request must be submitted.

The Department may charge you a fee for providing you with copies of your PHI or a written summary of your PHI, which may include the cost of labor, supplies and postage.

Special Notice Regarding Email: If you chose to receive the PHI through email, be advised that emails from the Department are unencrypted (unsecure), which means the added security protections that help safeguard the contents of emails are removed. The privacy and security of emails cannot be guaranteed. There is risk that PHI contained in emails may be misdirected, disclosed to, or intercepted by an unauthorized recipient. The Department will rely on the contact information you provide. The Department is not liable for emails that are not received due to technical failure or for improper disclosures of PHI. The Department is not responsible for any fees imposed by your email service provider. You should not agree to receive emails unless you are willing to accept these risks. Your signature on this document is your consent to receive the PHI through unencrypted (unsecure) emails from the Department. Your consent applies only to emails regarding this request to access PHI. Emails may be included in your Department record.

Select the format and delivery method of the PHI below (check only one). Please print clearly and verify the information provided is accurate.

<input type="checkbox"/> Mail PHI To:	Address	City	State	ZIP Code
<input type="checkbox"/> Email PHI To:	Email Address			
<input type="checkbox"/> Pick Up PHI. Notify Me When Ready for Pick Up:	Telephone Number	Email Address		
<input type="checkbox"/> Contact Me to Arrange Date/Time to View PHI in Person:	Telephone Number	Email Address		

All requests must be signed and dated. If you are signing this form as a legal representative other than a parent of a minor child, you must attach documentation that establishes your legal authority to act on behalf of the client if not already on file with the Department.

Signature of Client or Legal Representative	Date
If Legal Representative, Print Name	Relationship to Client

FOR DEPARTMENT USE ONLY

DETERMINATION: Note, all denials must be preapproved by the Department Privacy Officer or the Legal Division.

Date Request Received by Department		
Determination (check only one) <input type="checkbox"/> Approved <input type="checkbox"/> Approved with Staff Explanation <input type="checkbox"/> Denied in Part <input type="checkbox"/> Denied in Whole		
Comments		
Signature of Privacy Officer or Legal Authorizing Denial (when applicable)		Date
Printed Name of Department Representative	Signature	Date Completed

CLIENT REFUSAL OF STAFF MEMBER EXPLANATION

I, the above named client or the legal representative of above named client, have requested access to, or copies of PHI. I have been advised by representatives of the Department of their belief that it would not be in my best interest to access or obtain copies of certain PHI without an explanation from a staff member. I have refused that advice, and I continue to assert my request to access or obtain copies of PHI without explanation. I agree to hold the Department, as well as all other contributors to the PHI which I have requested access to, or copies of, harmless as to any damages I might incur or suffer due to my request.		
Signature of Client or Legal Representative		Date
If Legal Representative, Print Name	Relationship to Client	