

**CHILDREN'S RESOURCE GROUP (the "Practice")
PATIENT REQUEST TO ACCESS PHI FORM**

Name: _____

Date of Birth: _____

Description of Protected Health Information Requested:

For the purpose of:

1. This request will terminate sixty (60) days after the date listed below or upon the occurrence of _____, whichever occurs first.
2. I understand that the Practice may deny my request if it is permitted to do so by state and federal law.
3. I agree that the Practice may provide a summary of the information requested instead of copies of the actual records. I agree to pay the Practice all reasonable fees incurred in preparing the summary and providing it to me.

Patient (or Personal Representative*) Signature

Date

Printed Name

If signed by Personal Representative, state
relationship to Patient: _____

ORIGINAL: In Patient Record Under Privacy Tab
COPY: To Patient (or Personal Representative)

PART B

**CHILDREN'S RESOURCE GROUP
DECISION REGARDING PATIENT REQUEST TO ACCESS PHI**

Name and Address of Patient:

On _____, 20__, you requested access to inspect and/or copy certain protected health information or "PHI" about you.

Access to the following protected health information is:

_____ Approved (subject to any limitations described here): _____

_____ Denied (subject to any limitation described here): _____

The basis for any denial described above is as follows:

- The request is for Psychotherapy Notes. (Unreviewable)
- The information that is the subject of the request was created in anticipation of, or for use in a civil, criminal or administrative proceeding. (Unreviewable)
- A licensed health care professional has determined, upon advice by a physician, and in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of yourself or another person. (Reviewable)
- The information makes reference to another person, who is not a health care provider, and a licensed health care professional has determined, upon advice by a physician, and in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person. (Reviewable)

- The request for access was made by the patient's personal representative and a licensed health care professional has determined, upon advice by a physician, and in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person. (Reviewable)
- You are an inmate of a correctional institution and your obtaining a copy of such information would jeopardize the health, safety, security, custody, or rehabilitation of yourself or other inmates, or the safety of an officer, employee, or other person at the correctional institution or person responsible for your transportation. (Unreviewable)
- Other (Describe and state whether Reviewable or not):

If access is denied on a ground identified above as "Reviewable," you have the right to have the denial reviewed by a physician officer of the Practice who is designated by the Practice to act as the reviewing official, and who did not participate in the original decision to deny access. To have the above denial reviewed, please contact the Privacy Officer, in writing, at following address:

As stated in our Privacy Notice, you have the right to contact our Privacy Officer at any time if you wish to file a complaint about our privacy policies and procedures or if you believe we have violated your privacy rights. You also have the right to contact the Department of Health and Human Services in Baltimore, Maryland regarding these matters, particularly if you do not believe that we have properly responded to your request. The contact information, both for our Privacy Officer and the Secretary, is as follows:

_____, Privacy Officer
 _____, P.C.

 (317) _____

Privacy Complaints
 P.O. Box 8050
 U.S. Dept. of Health and Human Services
 Centers for Medicare & Medicaid Services
 7500 Security Boulevard
 Baltimore, Maryland 21244-1850

 Date

 Signature of Authorized Practice Official

ORIGINAL: To Patient (or Personal Representative)
 COPY: To Patient Record Under Privacy Tab

PART C

**CHILDREN'S RESOURCE GROUP
DECISION BY PRACTICE OFFICER WHEN DENIAL OF ACCESS IS REVIEWED**

Name and Address of Patient:

Dear _____:

On _____, 20__, you requested review of the Practice's denial of access to your protected health information or "PHI."

The Practice's reason for denying your request was *[state the reason]*.

Your request for review was referred to *[insert name of the Practice Officer who conducted the review]* on _____, 20__. Please note that this individual did not participate in the original decision to deny access.

At this time, I am writing to notify you that *[insert name of the Practice Officer who conducted the review]* has upheld/reversed the initial denial of access.

[If the denial was reversed, include the following paragraph] Please contact _____ who will arrange for your requested access to occur.

Very truly yours,

Authorized Practice Official

ORIGINAL: To Patient (or Personal Representative)
COPY: To Patient Record Under Privacy Tab