HIGH POINTE SURGERY CENTER
REQUEST FOR PATIENT ACCESS TO HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

I hereby request access to health information for:

_____

_____

(Print Patient's name and address)

Date of birth: _____

SCOPE OF ACCESS REQUESTED

I would like access to:

____	H&P	____	Lab Reports	____	O.R. /Anes. Notes	____	PACU Nurses' Notes
____	EKG	____	X-Ray Reports	____	Pathology Reports	____	Dr.'s Progress Notes
____	Other	____	O.R. Dictation	____	Discharge Summary	____	Discharge Instructions

(Specify portion of records in which you are interested. For example: anesthesia record, operative dictation, or diagnostic test results.)

TYPE OF ACCESS REQUESTED

☐ Inspection. Please let me know when I may come to inspect the records, and the amount of the charge, if any. I understand that an employee of High Pointe Surgery Center may be present and that I may not make any marks or alter the records in any way.

☐ Copies. I would like copies of all records requested.

LIMITATION OF ACCESS

You do not have a right to access the following: information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; information protected by the Clinical Laboratory Improvements Amendments of 1988 or records subject to the Privacy Act, 5 U.S.C. 552a; information obtained from someone other than a health care provider under a promise of confidentiality; any information if you are an inmate in a correctional facility and the correctional facility restricts access to such information; or information access to which a licensed health care professional has determined is reasonably likely to endanger the life or physical safety of any person.

Signed: _____ **Date:** _____

Print Name: _____**Telephone:** _____

If not signed by the patient, please indicate relationship:
☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient
☐ other (specify)

REQUEST PROCESSING TIME FRAME

We will take action upon your request within 30 days if the information is stored at our facility, and we will take action upon your request within 60 days if the information is stored at a different facility. If we are unable to act upon your request within this time frame, we will contact you with a reason for the delay.