Reset Form

GENOMICS AND NEWBORN SCREENING ACCESS REQUEST
State Form 55649 (R3 / 11-23)
INDIANA DEPARTMENT OF HEALTH
GENOMICS AND NEWBORN SCREENING PROGRAM

CONFIDENTIAL INFORMATION
per 45 CFR § 164.524

The purpose of this form is for a patient, legal guardian, or physician to request to inspect and/or obtain copies of protected health information or medical records (and designated record sets defined by 45 CFR § 164.501) maintained by us or our business associates, except that you are not entitled to inspect or obtain a copy of psychotherapy notes, information compiled in anticipation of or for use in any civil, criminal, or administrative proceeding, and certain information and records excluded from disclosure under 42 U.S.C. § 263a and other law.

To exercise your right of access, please complete and sign this form and submit it with a photocopy of your proof of identification as described below.

By mail to: Attn: Privacy Officer, Office of Legal Affairs
Indiana Department of Health
2 North Meridian Street Indianapolis, IN 46204

By E-mail to: NewbornScreening@health.in.gov

We require certain pieces of information so that we, the Indiana Department of Health *Genomics and Newborn Screening Program*, can process your request. If you have any questions, please call us at (888) 815-0006.

SECTION A: Information Requested.

Please *indicate* which information you are requesting for the person described below:

- ☐ **Newborn Screening Results for a child born in 2007 or before**
- ☐ **Newborn Screening Results for a child born in 2008 or after**
- ☐ **Dried Blood Spot Specimen Punch**

Results will be provided for Newborn Screenings ("*NBS Results*") for all conditions that were on Indiana's panel at the time of each newborn screening. *Dried Blood Spot Specimen Punches* are for further genetic testing within six (6) months and up to three (3) years after the birth.

- If you are requesting a copy of your NBS Results, please fill in your own information. Anyone who is at least eighteen (18) years old must complete their own request.
- If you are submitting this request on behalf of your child, please provide their information.

Please provide a brief description of the reason you want this information released:

_____

_____

Please describe the information you want released from your health record:

_____

_____

SECTION B: Patient Information.

Patient's Name at Birth:_____ Date of Birth *(month, day, year)*:_____

Address *(number and street, city, state, and ZIP code)*:_____

_____ Telephone:_____

Birth Mother's First and Last Names:_____

Location of Birth *(name of Indiana Hospital / midwifery where patient was born)*:_____

_____

SECTION C: Information of Person to Whom Records Are to Be Released.

Name of Person or Provider: _____

Address (number and street, city, state, and ZIP code): _____

_____ Telephone: _____

Fax:_____ E-mail:_____

By providing your email address you consent to receive communications about this form and this request by email.

Preferred delivery method for records: ☐ Encrypted E-mail ☐ Postal Mail ☐ Fax

SECTION D: AUTHORIZATION FOR ACCESS:

I understand that once the requested information has been disclosed, it may no longer be protected by the HIPAA Privacy Rule. I understand that any covered entity seeking this authorization may not require my signature on this form to provide or process treatment, payment, enrollment, or eligibility for benefits. I may revoke my authorization at any time, in writing, except to the extent that any action already was taken in reliance on my authorization. Written revocation will be effective upon receipt by the Privacy Officer. If I do not revoke this authorization in writing, this request for access will automatically expire:

☐ thirty (30) days from the date it was signed; or

☐ upon receipt of the requested records by the person named in Section C above; or

☐ after an event / condition occurs described as: _____

_____

_____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE: If the Patient is over age eighteen (18), then the Patient should sign and date below. If the Patient is under age eighteen (18), then the Patient's parent, guardian, or representative should sign and date below and provide their information.

Signature:_____ Date *(month, day, year)*:_____

Full Name *(print)*:_____

Full Name of Parent / Guardian *(print)*:_____

Relationship to Patient:_____ Date of Birth *(month, day, year)*:_____

Address *(number and street, city, state, and ZIP code)*:_____

_____ Telephone:_____

E-mail:_____ *By providing your e-mail address you consent to receive communications about this form and this request by e-mail.*

Identification is required for all requests for protected health information that are submitted under HIPAA. Below are lists of acceptable identification. **Please provide a legible photocopy of one item from List A OR two items from List B with your request.**

List A	List B
Provide a photocopy of one (1) of the following items:	If you cannot provide any items from List A, provide a photocopy of two (2) of the following items:
Valid Driver License *(both sides)*	Social Security Card
Valid State ID *(both sides)*	Stamped Social Security Printout
Work ID with Signature	Credit Card or Bank Card with Signature *(back side only)*
Military ID with Signature	Motor Vehicle Registration *(must be six (6) months old)* – NO VEHICLE TITLES
School ID with Signature	Valid Indiana Gun Permit
Veterans ID Card	Rental Agreement/Lease *(must be six (6) months old)*
Probation ID Card	Valid Professional License
Passport	State Agency Referral
	Employment Application *(must be six (6) months old)* – NO CHECK STUBS
	Employment Verification on Letterhead
	Library Card with Signature
	Previous Year Signed Tax Return – NO W2 STATEMENTS

We must respond to an access request within thirty (30) days of its receipt, unless the requested records are off-site, in which case we have sixty (60) days to respond.

***** RESERVED FOR USE BY INDIANA DEPARTMENT OF HEALTH STAFF*****

SECTION E: Request Process—Privacy Officer ("PO") to Complete or Provide in E-mail Response.

Date request received *(month, day, year)*:_____

Date request sent to PO *(month, day, year)*:_____

Date request approved and forwarded to Provider departments or business associates to search for requested records *(month, day, year)*:_____

Extension of response date: If response is not provided within thirty (30) days of request date, we may have one thirty (30) day extension by notifying the requestor within the original response period with the reason for the extension and the date on which we will provide our response.

Extension notice sent on *(month, day, year)*:_____

Response date in extension notice *(month, day, year)*:_____

Reason given for extension:_____

SECTION F: Request Denial—PO to Complete on Form or by E-mail ONLY if Request is Denied.

Denial of Request sent to Requestor on *(month, day, year)*: _____

Requestor requested review of Denial on *(month, day, year)*: _____ *(Attach request.)*

Requestor filed a Complaint on *(month, day, year)*:_____

(See COMPLAINT form for nature of complaint and its disposition.)

Request for Access was granted and sent to Requestor and approval was forwarded to Provider departments or business associates to search for requested records on *(month, day, year)*:_____

_____

SIGNATURE OF PRIVACY OFFICER – on Form or by E-mail Signature

I, an attorney in the IDH Office of Legal Affairs, attest that the above information is correct.

Signature:_____ Date *(month, day, year)*:_____

Full name (*print)*:_____Title:_____