HEALTH INFORMATION ACCESS REQUEST

State Form (R / 10-11)
Approved by State Board of Accounts, 2011

CONFIDENTIAL INFORMATION
per 45 CFR 164.524

INSTRUCTIONS: *Send Completed Form and Photocopy of Identification to:*
Office of Legal Affairs
Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204

Purpose: This form is used for an individual's request to inspect and/or obtain copies of the individual's protected health information or records in our designated record sets or the designated record sets of our business associates.

SECTION A: Participant Information.

Name: ______________________________

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

Telephone: ______________________ Date of Birth *(month/day/year)*: ______________

Social Security Number: ______________

The Social Security number is being requested by this state agency to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

SECTION B: 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: ______________________

SECTION C: To the Participant—Please read the following and complete the information requested.

You have the right to inspect and obtain a copy of your protected health information in designated record sets we or our business associates maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records. To exercise your right of access, please complete this Section B.

Please specify the records you wish to inspect or obtain copies of:

☐ Breast & Cervical Cancer ☐ Children's Special Health Care Services ☐ Hemophilia
☐ HIV Medical Services ☐ Indiana Lead and Healthy Homes Program ☐ Genomics/Newborn Screening

Do you wish to: ☐ Inspect these records? ☐ Obtain copies of these records?
☐ Release these records to another person or medical practice?

We will charge you $0.10 per side, per page to copy these records, if the total number of pages is over 100.
Do you want us to mail the copies? ☐ Yes ☐ No

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

____
____
____

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

____
____
____

AUTHORIZATION: I understand that once the authorized information has been disclosed, it may not longer be protected by the HIPAA Privacy Rule. I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization. I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on this request. Written revocation will be effective upon receipt by the Privacy Officer. Without my express revocation, this request will automatically expire: (1) upon satisfaction of need for disclosure; (2) on _____/_____/________ *(month/day/year)*; or (3) upon satisfaction of the following condition: ____
____
____

SIGNATURE OF PATIENT:

____ Date *(month/day/year)*: ____________________

If this request is by a personal representative on behalf of the participant, complete the following:

Personal Representative's Name: ____

Relationship to Participant:_______________________________ Date of Birth *(month/day/year)*: _______________

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

Telephone: ___________________________________Social Security Number: ______________________________

The Social Security number is being requested by this state agency to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

Send to:
Privacy Officer, Office of Legal Affairs
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Purpose: Identification is required from an individual when submitting a Health Insurance Portability and Accountability (HIPAA) request regarding Protected Health Information (PHI). Below are the lists of acceptable identification that can be provided by the individual. Please provide a photocopy of one item from List A **OR** two items from List B with your request.

List A	List B
Provide 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	Social Security Card
Valid State ID	Stamped Social Security Print-out
Work ID with Signature	Credit Card or Bank Card with Signature (backside 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

SECTION D: Access Request Processing—To be completed by Privacy Officer.

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

Date access request received: ____/____/____ Date transmitted to Privacy Officer: ____/____/____

☐ Appropriate Identification was received: ____/____/____

Date appropriate Provider departments and business associates directed to search for requested records: ____/____/____ Use Direction to Retrieve Records page to notify Provider departments and business associates.

Provider's departments directed to search their designated record sets for the requested records:

____ ____

____ ____

Business associates directed to search their designated record sets for the requested records:

____ ____

____ ____

Extension of response date:

We may take one thirty (30) day extension of our response date by notifying the requester within the original thirty (30) or sixty (60) day response period of the reason for the extension and the date on which we will provide our response.

Extension notice sent on: ____/____/____ Response date promised in extension notice: ____/____/____

Reason given for extension: ____

SECTION E: Response to Access Request—To be completed by Privacy Officer.

Access denied on ____/____/____ by transmittal of Denial of Access to Records to the individual.

☐ Individual requested review of licensed professional's determination on ____/____/____. Attach sheet explaining disposition.

☐ Individual lodged complaint on ____/____/____. See the COMPLAINT form for nature of complaint and its disposition.

Access granted on ____/____/____ by transmittal of Grant of Access to Records to the individual.

☐ Records inspected: ____/____/____

☐ Copies supplied: ____/____/____ Charges: $___________ Paid: ____/____/____

☐ Summary or explanation provided: ____/____/____ Charges: $___________ Paid: ____/____/____

SIGNATURE

I attest that the above information is correct.

Signature: ____________________________________ Date *(month/day/year)*: ______________________

Print name: ____________________________________ Title: ______________________________