REQUEST FOR ACCESS TO HEALTH INFORMATION

517 W. Grace Street Richmond, VA 23220 | PHONE: (804) 783-2505 EXT: 1779 | FAX: (804) 649-1635

As a patient of Daily Planet Health Services (DPHS), you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request, please complete this form and submit it to the front desk or send to the attention of the Medical Records Coordinator at the contact information above.

PATIENT INFORMATION	
Patient Name:	Date of Birth:
Date of Access Request:	Phone Number:

PERSON REQUESTING INFORMATION:		
Name:	Relationship to Patient:	Phone number:

PERSON WHO SHOULD RECEIVE INFORMATION:		
Name:	Relationship to Patient:	Phone number:

ACCESS METHOD

You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both.

☐ I would like an **ELECTRONIC COPY** of my protected health information.

- □ I would like Daily Planet Health Services send the copy via the secure patient portal
- □ I would like Daily Planet Health Services to send the copy via secure e-mail to the following e-mail address:
- □ I would like Daily Planet Health Services to send the copy via fax to the following number:
- □ I would like Daily Planet Health Services to provide a copy on a USB drive. An additional cost may apply.

☐ I would like a **HARD COPY** of my protected health information. I understand that Daily Planet Health Services may charge me $6.50 for a copy. I have selected my delivery method below (if none is selected, I will pick up the copy at the practice):

- □ I will return to Daily Planet Health Services and pick up the copy when it is ready.
- □ I would like Daily Planet Health Services to send the copy via U.S. mail to the following address:

☐ I would like to **VIEW** my protected health information. I have/will schedule(d) an appointment with Daily Planet Health Services to view my health information on _____. I understand Daily Planet Health Services may have a staff member sit down with me as I review my health information.

INFORMATION REQUESTED: *Specifically describe the health information requested, including date of service, other meaningful descriptors.*			
Date(s) of Service:			
□ Part of Record (specify below)	□ Laboratory Result(s)	□ Entire Record	□ Immunization Record
□ Mental Health Information (specify below)	□ Oral Health Information	□ Other (Specify below)	
Additional Information:			

SUMMARY OR EXPLANATION

□ *(CHECK IF DESIRED) I would like DPHS to provide to me a summary of the information requested in lieu of the record requested. I understand that Daily Planet Health Services may charge me a fee of for the summary.*

□ *(CHECK IF DESIRED) I would like DPHS to provide to me an explanation of the information requested. I understand that Daily Planet Health Services may charge me a fee for the explanation.*

I understand that DPHS has 30 days to process my request for access. DPHS may extend the deadline by an additional 30 days if necessary if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in the Code of Federal Regulations. By signing below, I acknowledge and agree to the above conditions.

_____ _____ _____ _____

Signature of Patient or Authorized Representative *Printed Name* *Relationship to Patient* *Date*

If you have any questions or concerns, please contact the Complliance Officer at (804) 783-2505 or by e-mail at scuttino@dailyplanetva.org. 4/2024

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FOR OFFICE USE ONLY

REQUEST RECEIVED/REVIEWED			
Access request received on:		Received by:	
Access request reviewed by:			
Request has been:	□ Accepted in full	□ Accepted in part	□ Denied
Letter indicating decision mailed to patient on:			

_____ _____

Signature of Reviewer *Date*

IF PATIENT WAS GIVEN ACCESS IN FULL, COMPLETE INFORMATION BELOW:			
The record was: □ Viewed by the patient on:		Staff member who assisted the patient in viewing his/her information was:	
□ Sent electronically on:			
□ Copied on:			
□ Picked up by patient on:	□ Mailed via US mail on:	□ Sent to patient via ____ on:	□ Faxed to patient on:

IF PATIENT WAS GIVEN ACCESS IN PART, COMPLETE INFORMATION BELOW:
Indicate which part(s) have been denied and the reason(s) why below:

REVIEW		
Has the patient asked for a review of the decision? □ No □ Yes		If yes, letter asking for review received on:
Decision reviewed on:		Decision reviewed by:
Reviewing official's decision:	□ Affirm decision	□ Overturn decision (complete the disclosure information above)
Patient notified of reviewing official's decision in letter/fax sent on:		

IF DENIED, COMPLETE THE INFORMATION BELOW:
If denied, indicate why the request has been denied (be specific):

COMMENTS OF HEALTHCARE PRACTITIONER OR REVIEWER: