SIOUX FALLS SPECIALTY HOSPITAL
Innovative and Personalized Care

MIDWEST IMAGING | MIDWEST PAIN SPECIALISTS | SIOUX FALLS URGENT CARE | WORKFORCE

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. You do not have the right to access certain types of health information If we do not grant you access to any health information, we will explain the reason for such denial.

I hereby request access to health information for: _____

_____

(Print Patient's name and address)

Date of birth: _____ Date of service: _____

SCOPE OF ACCESS REQUESTED

I would like access to:

___H&P
___Procedure Dictation
___O.R./Anes. Notes
___PACU/RC Nurse's Notes
___Discharge Instructions
___Discharge Summary
___Dr./PA/NP's Progress Notes
___Clinic Nurse's Notes
___Immunizations
___Lab Reports
___Pathology Reports
___EKG
___Images
___Image Reports
___MRI Report
___CT Report
___Other_____

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

INTENDED PURPOSE

_____

_____

(If you are requesting the disclosure of information to yourself, you may leave this section blank or write "at the request of the individual.")

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 the Sioux Falls Specialty Hospital may be present and that I may not make any marks or alter the records in any way.

☐ Copies.

___ I would like a paper copy of all records requested.
___ I would like an electronic copy of all records requested copied onto removable media.
___ I would like a copy of all my requested records emailed to me. I understand that unencrypted email transmissions may not be secure.
My email address is _____

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.

For Office Use Only: ☐ Picked-up ☐ Mailed ☐ Emailed ____Staff Initials/Department _____ (date)