COMMUNITY HEALTH ALLIANCE

Request for Accessing/Inspecting/Copying Health Information

As required by the Health Information 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. Community Health Alliance (CHA) will evaluate your request and will either grant it or explain the reason why the request will not be granted. Community Health Alliance may provide you with a summary or explanation of the information in your health plan records instead of access to or copies of your records.

INSTRUCTIONS: Mail or hand deliver this completed form to: Community Health Alliance, ATTN: Medical Records, 680 South Rock Blvd., Reno, NV 89502 or via fax at (775) 336-0652 or the health center where you receive care.

PATIENT'S INFORMATION

Full Name:		Health Care Record # or ID#:
Birthdate:	Contact Phone Number:	Request Date:
Current Address (No., street, city, state, zip):		

REQUEST TO ACCESS/INSPECT/COPY

I am requesting my health information in the following designated record set(s) for the period of time from ______________________ to ______________________: ☐ Pharmacy Records ☐ Medical Records (including behavioral health) ☐ Laboratory Reports ☐ Radiology ☐ Financial Records ☐ Dental Records ☐ Enrollment, payment, claims adjudication information maintained by CHA ☐ Behavioral Health ☐ Other agency designated record sets: ______________________________

REASON FOR REQUEST

Is the health information requested for any of the following purposes: ☐ Use in a civil, criminal or administrative action or proceeding ☐ Created or obtained by CHA in the course of research ☐ Was the protected health information obtained from someone other than a CHA health care provider under a promise of confidentiality.
If any of these are checked, CHA shall not approve the request to access PHI. CHA Comments: ______________
____ CHA Initials: _____

REQUEST SPECIFIC TO HIV/GENETIC TESTING RECORDS

The treatment records for results of HIV test results are specifically protected, and will not be disclosed unless you sign below.

☐ HIV Test Results ➡ Signature: ______________________________

☐ Genetic Testing Results ➡ Signature: ______________________________

Provider Approval Signature Required: ______________________________

Provider Name (Printed): ______________________________ Date:________

DELIVERY METHOD

Please check the box indicating how you would like to receive the requested health records.

□ **Mail to my current address:** ____
Street Address City State Zip Code

□ **Email to my personal email account as:** ______________________________

□ Pick-up (you will be required to provide photo identification.) Please provide a phone number where we may contact you when copies are ready for pick up. ______________________________

□ Review in person (you will be required to provide photo identification.) Any review of participant records will be conducted in the presence of a clinical staff member. Please provide a phone number where we may contact you to schedule an appointment. Phone number: ______________________________

This Section for Company Use Only

Determination:	☐ **REQUEST APPROVED.** Approved date: ____________
Agency Responsibilities:	☐ Determination of method for Participant access. Determination date: ____________
	☐ Notice to Participant of approved access. Sent date: ____________
	☐ Offer Participant summary of information. Sent date: ____________
	☐ Notify Participant of requirements for copies of health information. Sent date: ____________
Determination:	☐ **REQUEST NEEDS FURTHER REVIEW**
____________ Designated Staff	____________ Date

Review of Request by Licensed Health Care Professional

Determination:	☐ **REQUEST APPROVED.** Approved date: ____________
Agency Responsibilities:	☐ Determination of method for Participant access. Determination date: ____________
	☐ Notice to Participant of approved access. Sent date: ____________
	☐ Offer Participant summary of information. Sent date: ____________
	☐ Notify Participant of requirements for copies of health information. Sent date: ____________
Determination:	☐ **REQUEST DENIED. Denial date:** ____________
Reason for Denial:	☐ Reference made to another person could endanger that person
	☐ Access could endanger life or physical safety of Participant or other(s)
	☐ Access requested by personal representative and access could cause substantial harm to Participant or other(s)
	☐ Other ____________
Agency Responsibilities:	☐ Written Notice to Participant of basis for denial. Sent date: ____________
	☐ Provide Participant with Opportunity to Request Review by licensed health care professional Sent date: ____________
____________ Licensed Health Care Professional	____________ Date

Request Second Review

Determination:	☐ **REQUEST APPROVED**
Agency Responsibilities:	☐ Determination of method for Participant access
	☐ Notice to Participant of approved access
	☐ Offer Participant summary of information
	☐ Notify Participant of requirements for copies of health information
Determination:	☐ **REQUEST DENIED**
Reason for Denial:	☐ Reference made to another person could endanger that person
	☐ Access could endanger life or physical safety of Participant or other(s)
	☐ Access requested by personal representative and access could cause substantial harm to Participant or other(s)
	☐ Other ____________
Agency Responsibilities:	☐ Written Notice to Participant of basis for denial. Sent date: ____________
____________ Licensed Health Care Professional	____________ Date

ACKNOWLEDGEMENT

Please sign and date: I understand that I may be charged a reasonable cost-based fee for copying my records. Applicable mailing fees also may apply. With certain exceptions, you have the right to inspect or obtain a copy of your health information in a designated record set maintained by Community Health Alliance. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative action or proceedings and records that are subject to the Privacy Act, 5U.S.C. 522a.

I understand that if requesting my records by email, the records will be sent from CHA in a secure file format. I am responsible for the security of my email account and these documents, should a breach occur.

I further understand there may be circumstances when a licensed health care professional may deny my request for access to my health information; and that I am allowed to request a review by another licensed health care professional.

By: ______________________________ ______________________________ __________

Patient's Name (Print) Patient's Signature Date

If you are not the patient, please complete, sign and date below. Check the box that describes your relationship to the patient. Please attach proof or your relationship to the patient (e.g. Power of Attorney, legal guardian)

By: ______________________________ ______________________________ __________

Patient's Name (Print) Patient's Signature Date

□Parent of Minor Child □Legal Guardian □Power of Attorney □Executor □Other ____________________