

REQUEST FOR ACCESS TO HEALTH INFORMATION

- You have a right to request to inspect and copy health information Kings View maintains about you.
- We will evaluate your request and either grant or deny it. We will only deny your access for legal reasons.
- If you are denied, you'll be given a reason and told how to have the denial reviewed within 5 working days of your request.

I. REQUESTOR'S INFORMATION		
Name	Date	
Birthdate	Contact Telephone #	Last 4 #s Social Security
Address (#, street, city, state, zip) _____		
Identification: Driver's License #: _____ State ID Card #: _____ Other _____		
II. PROTECTED HEALTH INFORMATION REQUESTED		
I am requesting my health information for the time period of: From: _____ To: _____		
I want to <input type="checkbox"/> Inspect records onsite <input type="checkbox"/> Obtain a copy		
Specify Information Requested: _____ _____ _____		
III. DELIVERY METHOD		
<input type="checkbox"/> I will pick up (Bring photo identification)		
<input type="checkbox"/> Mail to my current address: _____		
_____	Street address	City State Zip
<input type="checkbox"/> Mail to: _____		
_____	Name (If not client) Street address	City State Zip
<input type="checkbox"/> Inspect records in person (bring photo identification). Record reviews are conducted in the presence of a staff member.		
IV. ACKNOWLEDGEMENT AND SIGNATURE		
I understand I may be charged a reasonable cost-based fee for copying records. I further understand there may be circumstances when a licensed health care professional may deny my request for access to my health information; and, if denied access, I am allowed to request a review by another licensed health professional.		
By: _____		
Print name	Signature	Date
IF you are not the client, please sign, date, and enter relationship to client below.		
By: _____		
Print name	Signature	Date
_____ Copy to Client: <input type="checkbox"/>		
If not the client, relationship to client		
Verification of Personal Representative's Authority: _____		
PRV.4.2017	RESPONSE TO REQUEST ON REVERSE SIDE	

V. REQUEST APPROVED

◆ Date Approved: _____ In Whole In Part ◆ Date(s) Requestor Notified: _____
◆ Information approved: _____
◆ Date of Inspection: _____ ◆ Date Copies Picked Up: _____
◆ Date Copies Mailed: _____ ◆ Fee: _____ ◆ Amount Paid: _____
_____ Medical Records Staff _____ Date

VI. REQUEST DENIED

◆ Date Denied: _____ In Whole In Part ◆ Date(s) Requestor Notified: _____
_____ MR Initials
◆ Information denied: _____
◆ Reason: A licensed health care professional has determined the information you requested—
1. Is not information you are legally authorized to access.
2. Is requested by a personal representative who is not legally authorized to access the information.
3. Was obtained from someone under a promise of confidentiality and the access would likely reveal the source.
4. Is not available from Behavioral Health Services.
5. Has been compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding.
REVIEWABLE:
6. Is reasonably likely to endanger the life or physical safety of you or another person.
7. The client is a minor and the information is reasonably likely to— harm the therapeutic relationship and/ or
 cause the minor physical harm and/or cause the minor emotional harm.
8. Is requested by a personal representative and is reasonably likely to cause substantial harm to the client or another person.

Licensed or Waivered Health Care Professional Date Program Supervisor Date

VII. REQUEST FOR REVIEW OF DENIAL OF ACCESS

If your request is denied for reasons 6, 7, or 8 you may request a review of the denial. Your request will be reviewed by a licensed health care professional who was not involved in the decision to deny access. You will be notified in writing of the final decision within thirty (30) days from when we receive your request. I request a review of the denial I do not want the denial reviewed

By: _____
_____ Print name _____ Signature _____ Date

If you believe your privacy rights were violated you may file a complaint with the—US Department of Health and Human Services (800) 368-1019 or with the Kings View Privacy Officer (559) 256-1080. **You won't be penalized for filing a complaint**

VIII. FINAL DECISION OF REVIEW OF DENIAL

REQUEST APPROVED ◆ Date(s) Requestor Notified: _____
◆ Date of Inspection: _____ ◆ Date Copies Picked Up: _____ ◆ Date Copies Mailed: _____
◆ Fee: _____ ◆ Amount Paid: _____
_____ Medical Records Staff _____ Date
 REQUEST DENIED Reason: _____
◆ Date(s) Requestor Notified: _____ ◆ Date written notice sent: _____

Licensed or Waivered Health Care Professional Date