PhyMed HEALTHCARE GROUP

**REQUEST TO EXERCISE PATIENT'S RIGHTS REGARDING PROTECTED HEALTH INFORMATION**

Name of Patient: _____ Date of Birth: _____

Please indicate below which right(s) you wish to exercise regarding your protected health information.

_____**Paper Copy of Medical Records.** You have the right to inspect and copy your health information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing, or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other federal or state needs-based benefits program.

_____**Electronic Copy of Electronic Medical Records**. If your health information is maintained in one or more designated record sets electronically, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic health information.
Contact information of person/entity to receive records: _____

_____**Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy.
If by Phone, call: _____May we leave a message? Yes / No
If by Email or Paper, mail to: _____

_____**Request Amendments.** If you believe that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information.
Reason for Request: _____

_____**Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.
Description of Specific Health Information to be Restricted: _____

_____**Restrict Certain Disclosures to Your Health Plan.** You have the right to restrict certain disclosures of health information to a health plan if the disclosure is for payment or healthcare operations and pertains to a healthcare service or item for which you have paid out-of-pocket in full. This request must be made at the time of service.
Description of Specific Health Information to be Restricted: _____
_____

_____**Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your health information. We are <u>not</u> required to list certain disclosures, including (1) disclosures made for treatment, payment, and healthcare operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. The first accounting of disclosures, you request within any 12-month period, will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting.
Time Period: _____
If by Email or Paper, mail to: _____

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Signature of Patient: _____ Date: _____

Name of Personal Representative (if applicable): _____ Relationship: _____

Signature of Personal Representative: _____ Date: _____

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