# ACCESS TO PROTECTED HEALTH INFORMATION

Date Received: _____

Initials of Privacy Officer/Designee:____

**SECTION A: Patient to complete the following information**

Requestor Name:_____ Date: _____

Patient Name: _____ Medical Record Number_____

Address:_____

**REQUEST:**
I request that The Jackson Laboratory provide me with access to my Protected Health Information as indicated below. **(Check all that apply)**:

___ The entire Medical Record (all information)
___ Informed Consent
___ Clinical Result Report: (specify test(s))
___ Laboratory reports and other diagnostic tests
___ Face Sheet
___ Complete Molecular Profile: (specify test(s)):
___ Other (describe in detail)

_____

_____

I request access to my health information covering the dates _____through _____.

**Type of Access Requested**

_____ Inspection of requested information or _____ Copies of requested information.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

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**SECTION B: The JLCE to complete this section**

**Request for access or copy is** (CLD or HIPPA Privacy Officer)_____ Accepted _____ Denied

If denied, check the reasons for denial:

_____PHI is not part of the patient's Designated Record Set

_____The requested information is psychotherapy notes

_____The requested information has been compiled for legal proceeding

_____The requested information was obtained under promise of confidentiality and access would be reasonably likely to reveal the source of the information

_____The requested information is temporarily unavailable because the individual is a research participant

_____Licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others

_____Licensed health care provider has determined that the requested information identifies a third person who may be physically, emotionally, or psychologically harmed if access to the information is granted

_____Licensed health care provider has determined that access to the requested information by the patient's personal representative could result in harm to the individual

_____We are acting under the direction of a correctional institution and letting the inmate access or obtain a copy of the requested information would jeopardize the health, safety, security, custody, or rehabilitation of another person at the correctional institution

_____The requested information is not maintained by The Jackson Laboratory

**RIGHT TO REVIEW:**

_____Yes

_____No – Contact the JLCE HIPAA Privacy Officer with any questions.

You have a right to file a complaint with The Jackson Laboratory and may do so by contacting our HIPAA Privacy Officer at:_____(insert phone number). You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. Contact our HIPAA Privacy Officer or see our Notice of Privacy Practices for additional information.

_____ _____

Signature of Privacy Officer Date

_____

Print name

If your request to copy the requested information has been granted, you will be charged a reasonable fee for photocopying and mailing.

**Distribution of copies: Original to patient's medical record, copy to patient.**