## SILVER STATE NEUROLOGY

## Request for Access to PHI (Protected Health Information)

**Patient Name:** _____ **Patient ID #:** _____

**I hereby request SILVER STATE NEUROLOGY to allow me to inspect and/or obtain a copy of the following records:**

**Description of records to be inspected/copied:** _____

_____

**And I understand that I can inspect my records free of charge. However, if I wish to obtain copies of the records or have the copies mailed to me, there is a nominal fee associated with the request which is:**

**Calculated fee for copying:** _____ **Calculated fee for mailing:** _____

**which covers the cost of copying and mailing the aforementioned records. I also understand that I may be required to pay the fee in full before I can obtain the copies. The aforementioned records can be mailed to me at the following address:**

**Address1:** _____ **Home Phone:** _____

**Address2:** _____ **Work Phone:** _____

**City/State/Zip:** _____

**I further understand that:**

1) All healthcare providers, including SILVER STATE NEUROLOGY, maintain certain protected health information about me as a patient, such as medical and billing records, and records that are used, in whole or in part, to make decisions about me, my treatment, or billing for services rendered.
2) I have the right to inspect and obtain a copy of my above mentioned protected health information maintained by SILVER STATE NEUROLOGY.
3) My request must be made in writing using this form, which must be completed prior to SILVER STATE NEUROLOGY providing me with the requested information.
4) If I request SILVER STATE NEUROLOGY to copy and mail the requested information, they have the right to charge me for copying and mailing the requested information to me.
5) I have the right to request an amendment to my protected health information mentioned above.
6) Within 30 days (60 days if information is not maintained or accessible on-site), I will receive a response from SILVER STATE NEUROLOGY indicating whether my request for access has been accepted or denied, or a notification that they require an additional 30 days to consider my request. If they require an extension, they will explain the reason for the delay and the date by which they will make a decision. If they deny my request, they will inform me in writing of the reason for the denial, and instruct me on how I can go about disputing a denial or filing a complaint.

_____ _____

**Signature of Patient or Legal Representative** **Date**

**Relationship to Patient (*if applicable*)**
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

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**Printed Name of Patient's Representative (*if applicable*)**

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**Request** ☐ Accepted ☐ Denied FOR OFFICE USE ONLY

**Reason for Denial** (*if applicable*)
☐ Access is likely to endanger the life or physical safety of the individual or another person
☐ Psychotherapy notes
☐ The information is compiled for use in a civil, criminal, or administrative action or proceeding
☐ Other (*full list of other reasons for possible denial at 45 CFR §164.524(a)(1)-(3)*):

**Date Request Received** _____ **Received By** _____

**Date Request Fulfilled** _____ **Fulfilled By** _____

**Extension Requested** ____Yes ____No **Date Patient Notified in Writing of Extension** _____

**If Extension Requested, Give Reason** _____

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