Request for Access to My Health Information

HIPAA Privacy Rule right of access, 45 CFR 164.524

How to use this template: fill in the blanks, tick the boxes that apply, delete anything you do not need, sign it, and send it the way the provider accepts records requests (records email, fax, portal message or mail). Keep a copy and note the date it was received. This letter uses your HIPAA right of access, which applies to health plans and most health care providers; if the provider says HIPAA does not apply to it, ask what your state's medical records law allows. Template provided by PatientPower (beyondmychart.com) for general information only; it is not legal advice. Once you receive your records, you can import PDF, FHIR, Blue Button or CSV files into PatientPower. Remove this paragraph before sending.

Date: _____

To: Medical Records / Health Information Management Department (or Privacy Officer)

Provider or practice name: _____

Address / fax / email: _____

Patient and requester

Patient's full name: _____ Date of birth: _____

Other names the patient used in your records (if any): _____

Requester's name, if different from the patient: _____

Address for delivery: _____

Phone: _____ Email: _____

Patient or account number (if known): _____

[ ] I am the patient. [ ] I am the patient's personal representative (relationship: _____); I can provide documentation of my authority if you need it.

My request

Under the HIPAA Privacy Rule right of access (45 CFR 164.524), I request a copy of the protected health information about me (or, if I am the personal representative, about the patient named above) that is maintained by or for you in your designated record set(s), as follows. This is an access request under 45 CFR 164.524; it is not an authorization for you to disclose information to someone else.

[ ] The patient's complete designated record set, including medical and billing records

[ ] Only the following, for dates _____ to _____:

- [ ] Visit and progress notes [ ] Lab and test results [ ] Imaging reports
- [ ] Medical images (for example X-ray, MRI, CT) [ ] Medication lists and prescriptions
- [ ] Referrals and letters [ ] Billing and payment records [ ] Other: _____

Format

Please provide an electronic copy in the following format, if it is readily producible in that format. If it is not, please contact me so we can agree on another readable electronic format.

[ ] PDF [ ] Also a machine-readable file if you can produce one (for example FHIR or C-CDA) [ ] Other: _____

[ ] I would prefer a paper copy.

Delivery

[ ] Secure email or secure download link to: _____

[ ] Your patient portal [ ] Mail to the address above (on a USB drive or CD for electronic copies or large images)

[ ] If you cannot send it securely, I accept delivery by unencrypted email after you tell me the risks.

Fees

Please tell me the approximate fee before you prepare the copy, and give me a breakdown of labor, supplies and postage if I ask. I understand that HHS guidance permits only a reasonable, cost-based fee for copies (labor for copying, supplies for a paper copy or for portable media I ask for, and postage if I ask for mail), does not permit charges for searching for or retrieving records, and does not permit per-page fees for records kept electronically.

You may go ahead without contacting me if the total fee is no more than: $_____

Timing

Please act on this request no later than 30 calendar days after you receive it. If you need an extension, please tell me in writing within those 30 days the reason for the delay and the date you will act. If a state law gives me a shorter deadline or lower fees, please apply it. If part of the records are not available yet, I am happy to receive them in parts.

If you deny any part of this request, please send me a written denial that explains the reason, whether and how I can ask for a review, and how to file a complaint, and send me the rest of the records. If you do not hold some of these records but know who does, please tell me where to send my request. If you need to verify my identity, please contact me at the phone number or email above.

Signature

Signature: _____ Date: _____

Printed name: _____

Reference: U.S. Department of Health and Human Services, Office for Civil Rights, "Individuals' Right under HIPAA to Access their Health Information, 45 CFR 164.524" (hhs.gov/hipaa/for-professionals/privacy/guidance/access). Deadlines and fee limits in this letter are summarized from that guidance and from 45 CFR 164.524.