

Request for Patient Access to Protected Health Information

Mississippi State Department of Health, Privacy Officer
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Si necesita esta información en español, por favor llame 1-866-458-4948

Under the **Health Insurance Portability and Accountability Act** (“HIPAA”) of 1996, you have the right to request the opportunity to inspect and obtain a copy of your **protected health information** (“PHI”). The **Mississippi State Department of Health** (“MSDH”) will evaluate your request and either grant it or explain the reason why it will not be granted. Your right to access does *not* extend to:

1. Psychotherapy notes;
2. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
3. PHI that is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, if the denial of access under the Privacy Act would meet the requirements of that law;
4. PHI obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information;
5. Access to PHI that a licensed health care professional has determined, in the exercise of professional judgment, is reasonably likely to endanger the life or physical safety of you or another person;
6. PHI that makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
7. Requests for access made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to the personal representative is reasonably likely to cause substantial harm to you or another person.

I, _____,
(Patient's name – first, middle, last, maiden)

hereby request access to my Protected Health Information as indicated below:

Information to be disclosed:

Only the period of events from: _____ to _____
Only Information Related to (please check off all that apply):

- ☐ Breast and Cervical Cancer Program
- ☐ Child Health
- ☐ For CMP Use Only _____
- ☐ Consultation Reports*
- ☐ Complete Medical Record
- ☐ Cool Kids Program (EPSDT) Early and Periodic
- ☐ Diabetes
- ☐ Early Intervention
- ☐ Family Planning **
- ☐ Financial Records
- ☐ Genetics
- ☐ HIV/AIDS

- ☐ Hospitalization
- ☐ Hypertension
- ☐ Job Related *** (specify) _____
- ☐ Laboratory Test*
- ☐ Maternity (Prenatal)
- ☐ Medical History* _____
- ☐ Medication Records
- ☐ Progress Notes* _____
- ☐ Screening, Diagnosis and Treatment Program
- ☐ STD (other than HIV/AIDS)
- ☐ Other (specify) _____

- ☐ Psychotherapy notes ONLY. Requests for psychotherapy notes cannot be combined with any other Authorization; if you wish to authorize the disclosure of psychotherapy notes in addition to other information, please fill out a separate Authorization form for the additional information.

* Identify Program by Name

** Family Planning records will ONLY be released to the patient named on the record.

** Medical information pertaining to treatment or a condition that is related to absence from work, return to work, and/or any specific restrictions such as but not limited to typing, physical locomotion, driving, lifting, standing or sitting.

Type of access requested:

☐ Inspection. Please let me know when I may come to inspect my records. I understand a MSDH staff member will be present and that I may not make any marks or alter the records in any way.

☐ Copies. I would like copies of all records requested. I understand that MSDH may charge me a reasonable fee of \$0.25 per page for copies (single sided), \$1.25 per page for FAX copies, \$7.00 per CD, \$10.00 for clerical assistance or other possible costs for supplies or postage. The total amount charged will not exceed \$25.00.

☐ I would like the information in the following form/format (*specify paper, CD, or etc.*): _____
Choose one:

☐ I will pick up the requested copies on _____ (mm/dd/yyyy).

☐ Please send the requested copies to (*list mailing address or fax number*): _____

Charges:

☐ I hereby agree to pay any reasonable costs or fees, as specified above. Please bill me (*once payment is received, the records will be released*).

☐ Please contact me to let me know the total cost that I will incur.

Signature: By signing below, I hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

(Patient's Name)

(Date of birth – mm/dd/yyyy)

(Social Security Number – xxx-xx-xxxx)

(Patient Identification Number)

(Mailing address)

(Telephone number)

(E-mail address)

(Signature**)

(Date signed – mm/dd/yyyy)

****If not signed by the Patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient** _____

To get a copy of MSDH's Notice of Privacy Practices, visit <http://www.msdh.ms.gov>, contact a MSDH county office, or contact MSDH at the above address or telephone number.

REQUEST FOR PATIENT ACCESS TO PROTECTED HEALTH INFORMATION

Form 1110

PURPOSE

To provide a means for MSDH patients or employees to authorize the release of their health information to the themselves.

INSTRUCTIONS

Section 8.0 (Medical Records) of the department's *General Agency Manual* provides specific guidance on the release of patient information in accordance with 45 C.F.R. §164.508 and §164.520 of the HIPAA Privacy Rule.

The patient or individual must complete and sign Form #x to authorize the release of their information to themselves.

Step 1: On page 1, the patient will need to enter their first, middle, last, and maiden name, if applicable.

Step 2: On page 1 under "Information to be disclosed", the patient must indicate the dates of service and specify the records being requested by checking the boxes listed.

Step 3: On page 2 under "Type of access requested" the patient must indicate the how they would like to access their records.

Step 4: On page 2 under "Charges", the patient must indicate how they would like to be billed.

Step 5: The patient will then need to sign the form under the Signature section on page 2. Please make sure this section is completely filled out and the patient's identity is verified before any records are released.

Note: Please note if this form is not signed by the patient, the person signing the form must indicate their relationship to the patient and attach any required documentation confirming their authority to act for the patient (e.g. power of attorney, divorce decree/custody agreement, etc.)

OFFICE MECHANICS AND FILING

Release of Information to Patient – Complete the Release of Information, with signatures and make one copy. Place the original in patient's file. Make copies of patient information requested and attach a copy of the Release of Information with the patient records.

RETENTION PERIOD

Retain according to agency policy for that type patient retention schedule.

MSDH SCHEDULE FOR PROVIDING PATIENT INFORMATION

Section 8.0 (Medical Records) of the department's *General Agency Manual* requires that a reasonable fee be charged for copies of patient information provided to patients.

- *Fee Schedule - \$10.00 base rate and .25 cents per page for copies of records*

Exemptions from the Fee Requirement

- Maternity records
- WIC records given to a WIC client transferring to another provider
- Initial lab test results
- Immunization records – copy upon receiving a vaccination is free
- Records transferred to another health care provider pursuant to patient care
- Records transferred to the Department of Education, Human Services, or any other social service agency relative to patient care, referral or consultation
- Records provided to an insurance carrier as needed for reimbursement