

Grand Valley Surgical Center, LLC

Privacy Officer, 790 Wellington Ave Ste 21, Grand Junction, CO 81501
Phone: (970) 255-7800 Fax: (970) 255-7850

PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

You have the right of access to obtain a copy or inspect your medical information held by Grand Valley Surgical Center. The Center is not always required to grant such access but each request will be carefully reviewed and approved if warranted. Access to psychotherapy notes and information while research is in process shall be restricted. You will be notified when your request has been approved or denied and the reasons for any denial.

Expiration: This authorization expires upon completion of request.

- I hereby request access to my **private health information (PHI)** as described below, or
- I am requesting access as the patient's personal representative:

Patient Name: _____ Birth date: _____

Address for receipt of notice: (Patient or Personal Representative Street, City, State, Zip Code)

Telephone: _____ Fax: _____

I wish to review **or** receive a copy of the following medical information:
Please check applicable box(es) and provide as much detail as possible:

- operative reports
- pathology reports
- radiology (x-ray) reports
- consultation reports
- laboratory tests
- history & physical
- discharge summary
- anesthesia record
- progress & nursing notes
- other medical records (please specify)** _____

For services provided on (dates): _____

Delivery: Will pick up copy Visit to inspect Mail Fax to number listed above

Signature of Patient or Personal Representative

Date

If Signed by Representative, Relationship to Patient

Phone Number

Date

Representative's Address (Street, City, State, Zip Code) Witness

Note: Please allow for 3 – 5 business days processing time for completion of photocopies for this request. The federal regulation requires that Grand Valley Surgical Center comply with your request within 30 – 60 days.

Grand Valley Surgical Center, LLC

C:\Documents and Settings\Lhead\Desktop\New Folder\Patient Request to Access PHI.doc

Acct #: _____
Data _____
Verified: _____
Completed by: _____

PATIENT REQUEST TO ACCESS PHI

Patient's Acknowledgment of Access to Medical Records

I hereby acknowledge that I or my designated representative have inspected and/or received photocopies of my medical record.

Patient Name: _____

Signed: _____ Witness: _____
(patient or personal representative)

We are permitted by law to deny your entire request or a part of your request for one or more of the following reasons:

- *Your Patient Access Request for PHI Form is not signed by you or your representative;*
- *Your Patient Access Request for PHI Form is signed by your representative and the representative has not provided information on the source of his/her authority to act for you;*
- *We do not maintain the information you have requested to copy or inspect;*
- *The information you have requested is not part of your records;*
- *Your request is for psychotherapy notes and/or psychiatric medical records, which may be released with physician approval only;*
- *Your request includes information compiled for litigation and is protected by law from release;*
- *Your request includes information held by our laboratory that is not accessible by law;*
- *Your request includes information created or obtained in the course of research still in progress that includes your treatment and you agreed to this denial of access when consenting to participate in the research;*
- *A licensed health professional has determined that the requested access is likely to either endanger you or another person's life or safety or cause substantial harm to you or another person;*
- *Your request is to copy information and you are an inmate in a correctional facility (you retain the right to inspect the information only); or*
- *Your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.*