PME003-APPENDIX A Request to Inspect and Obtain Copy of Designated Record Set

For addressograph plate

JOHNS HOPKINS INSTITUTIONS

REQUEST TO INSPECT AND OBTAIN COPY OF A DESIGNATED RECORD SET

I, _____, request access to _____
<insert name> <insert "inspect", "copy" or "inspect/copy">
the following designated record set(s) for _____:
<insert "myself" or another name>

□ Complete Record (all) □ Abstract Record (discharge summary, operative notes and test results)
□ Discharge Summary □ Operative Report □ Pathology Report
□ Outpatient Record □ Drug & Alcohol Treatment Record □ Immunization Record
□ Mental Health Records □ Admission History & Physical □ Emergency Room Record
□ Diagnostic Test/Results/Reports (lab, x-rays and other test results) □ Billing Record
□ Other:

I request access to the above designated record set(s) covering the period of time:

_____
<insert to and from date(s)>

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State and federal guidelines. I agree to pay any such fees upon signing this request.

Patient Name:	_____ (first) (m. initial) (last)
Signature:	_____ **Date:** _____
Address:	_____ (street address)
	_____ (city) (state) (zip code)
Phone:	_____ (area code) (home phone number)
Medical Record #:	_____
Birth Date:	_____

For healthcare agent/court appointed guardian/surrogate/parent/informal kinship care relative or Personal Representative of the deceased,
(circle one of the above)

I , _____ , confirm that I am the representative for the patient as circled above.
(insert your name)

Representative's Signature _____

Address: _____ **Phone:** _____

If you are the healthcare agent, court appointed guardian, relative providing informal kinship care or court appointed Personal Representative of the deceased, please attach proof of your authority to act on behalf of the patient.

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If copies are requested and you would like the copies sent to a different address than you provided above or faxed to you, please fill in the following:

Patient/ Representative Name:	(first) (m. initial) (last)
Mailing Address:	(street address)
	(city) (state) (zip code)
Fax Number:	
Phone:	(area code) (home phone number)

1. I understand that I am not able to access the following health information:
   a. That is not part of a designated record set;
   b. Psychotherapy notes;
   c. Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; or
   d. Information access to which is prohibited by law.

2. I understand that Johns Hopkins will respond to me within 21 working days after the receipt of this request.

3. If Johns Hopkins grants my request, Johns Hopkins will provide me with access to the requested information in the form or format requested by me, as long as the information is readily producible in that form or format. Otherwise, Johns Hopkins will provide me with access to the requested information in hard copy or another format we agree upon. Johns Hopkins may provide me with a summary or explanation of the requested information if I agree, before signature, to accept a summary or explanation and I agree, in advance, to pay a reasonable, cost based fee (if any) for the summary or explanation.

4. If Johns Hopkins grants my request, Johns Hopkins will provide access within the time specified in step 2 above, including arranging a time for me to inspect or obtain a copy of requested information. If I request, Johns Hopkins will mail me a copy of the requested information to the address on the first page of this form, or to the alternative address specifically provided on this page, or to the fax number specified on this page.

5. If Johns Hopkins denies part of my request, Johns Hopkins will, to the extent possible, give me access to the information requested that I am allowed to access.

6. I understand that Johns Hopkins may deny my request for access. I am not entitled to a denial review if :
   a. I am not entitled to access the information I requested as stated in paragraph 1 above; or
   b. The requested information was 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.

7. I understand that Johns Hopkins may deny a request for access, but that I am entitled to have my denial reviewed if a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger my life or physical safety or the life or physical safety of another person.

8. If I am entitled to a denial review, I agree to complete the form titled “Request for Review of Denial to Access PHI.” I understand that a licensed health care professional designated by Johns Hopkins will review denials of access. The licensed health care professional will not have participated in the original decision to deny access. I will receive written notice, within a reasonable time, whether my request will be granted. I understand that Johns Hopkins will abide by the decision of the reviewer.