



## REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

### GENERAL INFORMATION

Please print the following information:

Phone Number \_\_\_\_\_

Patient's Name \_\_\_\_\_ ☐ Male ☐ Female

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### PROTECTED HEALTH INFORMATION REQUEST INSTRUCTIONS

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules, I request to review Protected Health Information (PHI) held by Advanced Imaging of Tulsa about (check one) ☐ Me, ☐ My minor child, ☐ My legal dependent, ☐ deceased individual, or ☐ other \_\_\_\_\_ (relationship to requester.) This PHI is contained in \_\_\_\_\_'s (name of patient) medical records, and may include information such as prior medical history, diagnosis, treatment, prescription, billing, and insurance records.

I, \_\_\_\_\_, request access to PHI covering the dates of:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (inclusive.) If not patient, please complete the following, and attach proof of personal representative status to this form.

Name of Personal Representative: \_\_\_\_\_

Relationship: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor Other \_\_\_\_\_

### AGREEMENT

#### I UNDERSTAND THAT:

- Advanced Imaging of Tulsa cannot give PHI requested to anyone other than the patient, the patient's legal guardian, or the patient's personal representative.
- If the patient, the patient's legal guardian, or the patient's personal representative is unable to personally pick up the PHI, it will be mailed to the patient's address listed above
- Advanced Imaging of Tulsa has thirty (30) days to respond to this request, and if someone else holds the PHI I'm requesting or it is off-site, then Advanced Imaging of Tulsa has sixty (60) days to respond to this request.
- Advanced Imaging of Tulsa may charge a reasonable cost-based fee for providing this service pursuant to the Oklahoma Statutes.
- This request does not apply to PHI that is: a) held by any other entity affiliated with Advanced Imaging of Tulsa; b) compiled in reasonable anticipation of litigation; and c) not subject to the right of access under HIPAA Privacy Rules; and
- The requested PHI will be provided in the form and format requested, if readily producible; otherwise, in a readable hard copy format, electronic format or other format agreed to by Advanced Imaging of Tulsa and you.

**SIGNATURE**

Requesting person's Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date of request \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**IF YOUR REQUEST IS DENIED**

If your request is denied you may file an appeal with the HIPAA Compliance Officer, or the Department of Health and Human Services. If you file a complaint with the HIPAA Compliance Officer, please send it to:

Valerie L. Dye  
HIPAA Compliance Officer  
Advanced Imaging of Tulsa  
6757 S. Yale Ave.  
Tulsa, OK 74136  
Phone: (918) 359-5948  
Fax: (918) 359-5949

**FOR INTERNAL USE ONLY**

Identity verified by: \_\_\_\_\_ Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date sent: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**RESOLUTION TO THE ACCESS REQUEST**

- ☐ The access request has been **granted**.  
☐ Advanced Imaging of Tulsa will print the records for the dates indicated on this form.  
☐ \_\_\_\_\_

☐ The access request has been **denied** for the following reasons: \_\_\_\_\_  
\_\_\_\_\_

**If the request is denied, provided a copy of this form to the patient and to the HIPAA Compliance Officer.**

**The patient has a right to have the denial reviewed by the HIPAA Compliance Officer. If the patient would like the denial reviewed, please check the appropriate box.**

- ☐ **Yes, the patient WOULD like the denial reviewed**  
☐ **No, the patient WOULD NOT like the denial reviewed**

Completed by: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_