BAR CODE LABEL

RUSH UNIVERSITY MEDICAL CENTER

HIPAA PRIVACY PATIENT RIGHTS REQUEST FORM

PATIENT RIGHT REQUESTED: (check the patient right(s) you want to exercise)

- ☐ **Access Medical Record**
- ☐ **Confidential Communications****
- ☐ **Restriction Request**
- ☐ **Accounting of Disclosures**
- ☐ **Amendment Request**

Please provide us with the following information:

Patient's Name:	**Telephone Number:**	
Address:		
City:	**State:**	**Zip Code:**
Social Security Number:	**Date of Birth:**	

ACCESSING YOUR MEDICAL RECORD

You have the right to inspect and obtain a copy of your protected health information in the medical record that Rush maintains. To exercise your right of access, please complete the following:

Type of access requested	**Select information to be copied or inspected**	
☐ Copies of the record ☐ Inspection of the record	☐ Abstract/Pertinent Information ☐ Operative/Procedure Report ☐ Cardiac Studies ☐ Nursing Notes ☐ Imaging/Radiology	☐ Emergency Room ☐ Lab ☐ MD Progress Notes ☐ Entire Medical Record ☐ Consultation
	☐ Other: _____	

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location. ****This request is limited to the department in which you make the request.**

To exercise this right, please indicate which department and complete below: _____
DEPARTMENT

Describe the protected health information you want to make subject to confidential communication:

☐ lab results ☐ treatment information ☐ billing

☐ Other: (please explain): _____

How do you wish for this department to communicate with you?

☐ Phone number: _____ ☐ E-mail Address: _____

☐ Fax number: _____ ☐ Other: (please explain): _____

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RESTRICTON REQUEST

You have the right to request that Rush restrict the use or disclosure of your protected health information, including for treatment, payment or our health care operations. Rush is not legally obligated to honor your request. The Rush Privacy Office administers ALL restriction requests. To exercise your right to request restriction on the use or disclosure of your protected health information, please complete the following:

Specify the protected health information, the use or disclosure of which you want to restrict:

☐ lab results ☐ treatment information ☐ billing

☐ Other: (please explain): _____

_____

State the restriction you want to apply to that protected health information:

_____

_____

ACCOUNTING OF DISCLOSURES

You have the right to an accounting of the disclosures Rush or its business associates have made of your protected health information. You are entitled to one free disclosure accounting every 12 months. Rush will charge you $_____ for each additional disclosure accounting you request during the same 12-month period. To receive an accounting of disclosures please provide the dates of disclosures you want us to account for:

From: _____/_____/_____ **To:**_____/_____/_____

AMENDMENT REQUEST

You have the right to request that Rush change or amend your protected health information in the medical record that Rush maintains. Rush may deny your request in certain circumstances. The Privacy Office administers ALL amendment requests. To exercise your right to request amendment, please complete the following:

Specify the records you wish to amend and the amendments you wish to make:

☐ lab results ☐ treatment information ☐ billing

☐ Other: (please explain): _____

_____

State the reasons for the amendment request: _____

_____

Contact Information: Privacy Office, Rush University Medical Center, 707 South Wood, Suite 317, Chicago, IL 60612-3833
Telephone: (312) 942-4416 • Fax: (312) 942-6875 • Email: **hipaaquestions@rush.edu**

PATIENT'S SIGNATURE: _____ **Date:** _____

If this request is by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Personal Representative's Signature: _____

Relationship to Patient: _____