PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ______________________________ **Patient DOB:**____________________________

Patient Representative (if applicable): ______________________________ **Authority of Personal Representative:**____________________________

Address: ______________________________ **Telephone #:**____________________________

City, State, Zip: ______________________________ **Account # or SS #:**____________________________

Site of Recent Services:______________________________ **Date of Recent Services:**____________________________

Patient Right to Access and Obtain Copy of Protected Health Information (PHI)

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides me with the right to inspect and obtain a copy of my Protected Health Information as it is maintained in a Designated Record Set, for as long as it is maintained Alliance HealthCare Services, Inc., its subsidiaries and affiliates (Alliance).

I hereby request access to inspect my PHI maintained by or for Alliance. I realize that I have the right to inspect my PHI at no charge if the inspection is conducted in Alliance's offices. Alliance may charge a fee for providing access to my PHI at a location other than its offices.

If indicated below, I also request to obtain a separate copy of my PHI. I understand that Alliance is permitted by law to charge a fee to cover reasonable associated copying and postage expenses. I further acknowledge that my payment of any such fee may be required before I am provided with a copy of my PHI.

Exceptions

I understand that HIPAA and other applicable statutes define certain circumstances under which Alliance may deny my request for access to PHI maintained about me and that I may or may not have the opportunity to seek review of the denial.

Instructions to Patient

1. Please fully complete, sign and date this form.
2. Provide the signed completed form to an Alliance employee or send via mail to: Alliance HealthCare Services, Inc., Attn: Privacy Official; P.O. Box 6600, Newport Beach, CA 92658

PATIENT TO SELECT ONE OF THE FOLLOWING

O Please contact me to confirm the time and office location to conduct my inspection of PHI maintained by Alliance about me. I reserve the right to request that I obtain a copy of my PHI at the time of inspection.

O In lieu of inspection in Alliance's offices, I would like to obtain a copy of my PHI as it is maintained in Alliance's designated record set. Please contact me if payment of a fee is required. Upon payment of the applicable fee and unless other arrangements have been made, the copy should be mailed to the address listed above, or to the entity or person designated below.

O If Alliance maintains my PHI in an Electronic Health Record, I am requesting a copy of that PHI in an electronic format.

O Please send my PHI to: ____

Patient Signature: ____ ***Date:*** ______________________

***** For Alliance Use Only *****
Response to Patient Request for Access to PHI

O Your request has been approved. Per our conversation, your appointment has been set for:

Date: ___________________ TIME: __________ AM / PM AT: ________________________________

Contact Name: ______________________________________ Phone:______________________________

O Your request has been approved. Please find a copy of your PHI attached.
O Part of your request has been denied. Please find an explanation, including your rights regarding that denial, attached
O Your request has been denied. Please find an explanation, including your rights regarding that denial, attached

Signature: __________________________________ ***Date:*** _______________________

Name/Title: __________________________________

[1] "Designated Record Set" is a group of records maintained by or for Alliance that are used, in whole or in part, to make decisions about a patient.