CenterWell

Access to Protected Health Information (PHI) for Patient

Please print all requested information to prevent delays in our response & provide completed form to your facility.

Patient Name: _____ _____ _____
Last First MI

DOB _____ Phone: _____

Address: _____

City: _____ State _____ Zip _____

E-mail Address: _____

I request access to my protected health information maintained by this medical organization. I understand that this request will be considered and a response provided within the required state or federal timeframe. If my request is denied for any reason, I will receive a written explanation of the reason for the denial.

I understand that my medical record may contain sensitive information such as mental health, HIV, AIDS, substance abuse, sexual abuse and /or other related conditions. I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an express and informed written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative of as provided by state or federal law.

I understand that a form is required for each request for information.

I hereby request copies of information contained in my medical records to include the following:

_____ **Discharge Summary**
_____ **Treatment Plans**
_____ **Labs**
_____ **Immunizations**
_____ **Psychological / psychiatric Evaluations**
_____ **All of my medical records including sensitive information (such as mental health, HIV, health status, sexual abuse or substance abuse records)**
_____ **other (describe)**

_____ **Progress Reports/ Notes**
_____ **Social Development History**
_____ **X- Rays**
_____ **Special Studies (EKG, Mammogram, etc.)**

I authorize release/request of information covering treatment dates of:

_____

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Patient Name:_____ **Date of Birth:**_____

Requested method for responding to this request:

- ☐ **Received information today**
- ☐ **Paper copy to be mailed by USPS to address indicated above.**
- ☐ **Call at telephone number** _____ **for pick up**
- ☐ **Fax documents to me at:** _____ **(Fax #)**
- ☐ ***Email sent encrypted to:**

***For security of your information, all emails are sent encrypted unless requested unencrypted with recognition of risk.**

- ☐ ****Email sent unencrypted to:** _____

**** I understand that records sent through unencrypted email pose a security risk but it is my requested method.**

Signature of Patient _____ **Date** _____

Parent/Legal Guardian/Authorized Person Relationship to patient

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FOR INTERNAL USE ONLY

Complete the sections below and place in patient record.

Notice of Decision is:

☐ **Approved and provided per request** ☐ **Denied for reason indicated below**

☐ Information requested is not part of patient's designated record set.

☐ Information requested is not available to the patient for access as required by federal or state law.

☐ A physician has determined that access to information requested may endanger the life or physical safety of the individual or another person

_____

Staff member who processed request **Title** **Date**

If denied, patient response letter will be sent.

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Important!

At CenterWell Senior Primary Care, it is important you are treated fairly.

CenterWell Senior Primary Care (CenterWell) does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. CenterWell complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CenterWell, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-2188** or if you use a **TTY**, call **711**.

- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

CenterWell provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어(Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت سرویس‌های زبانی به‌صورت رایگان با شماره فوق تماس بگیرید. **Diné Bizaad**

ËNavajoħ: W0dah7 b44sh bee hani'7 bee wolta'7g77 bich'9' h0d77lnih 47 bee t'11 jiik'eh saad bee 1k1'1n7da'1wo'd66 nik1'adoowo[.

العربية (Arabic)

الرجاء االتصال بالرقم المبين أعاله للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220