Request for Access Rights- Limited Request for the office of Columbia Urological Associates

Patient's Name _____ Date _____

Patient's birth date _____

Protected health information requested:

- ☐ Ledgers showing fees and payments
- ☐ Insurance payments received
- ☐ Clinical Information, please list _____

_____

Information to be received in the following form or format:

- ☐ I am requesting a hard copy mailed to my address of record.
- ☐ I am requesting a hard copy faxed to my authorized fax number.
- ☐ I am requesting an electronic copy transmitted to my unencrypted, clear, specific, conspicuous and authorized email address _____ or portal address.

If access is denied, an official Decision letter will be provided to you. If you wish to be contacted as soon as possible, please list how or where you wish to be contacted about receiving a summary of your information.

_____

_____

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

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Office Use Only:

Receiving Employee_____ Date received_____

**All employees will forward requests immediately to the Privacy Officer