Request for Access to PHI by Patient/Personal Representative

This form is to be used when patients or their Personal Representative request access to, or copies of, their designated record set. In addition, patients or their personal representative may direct CHCO to provide copies of their information to a third party of their choosing. All requests for access or copies of records must be submitted in writing.
This form is not to be used as a HIPAA Authorization.

Patient Name _____ **Date of Birth** _____ **Medical Record #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Type of Access Requested

☐ **Request for Access to View Records** (will be scheduled within 24 hours, excluding weekends and holidays)

To be completed by CHCO HIM staff: _____ *Date* _____ *Time* _____ *Location*

☐ **Request for Copies of Designated Record Set** (will be provided within 10 business days)

1. **Requested format**: ☐ Paper ☐ CD (for records CHCO maintains electronically)
2. **Delivery method:**

☐ Mail: _____ Attn to:_____
Address, City, State, ZIP

☐ Email:_____ Attn to:_____
NOTE: Unencrypted email is **not protected** from unauthorized access by unknown third parties once it leaves Children's Hospital Colorado's electronic systems and may be subject to unauthorized use or disclosure. All emails will be sent **encrypted** unless you specifically request they not be by checking this box: ☐

☐ Fax: Please fax the record to _____

☐ Pick-up from CHCO's Health Information Management department
Please call me at this phone number when the records are ready:_____

3. **Record Information requested**

Hospital Records
☐ Inpatient records ☐ Emergency Department ☐ Surgery/Procedure Reports
☐ Outpatient records ☐ Pharmacy ☐ Other:_____

Test Results
☐ Radiology Reports ☐ Cardiology ☐ Lab/Pathology ☐ Other:_____

Billing/Payment
☐ Itemized Statement ☐ Payments ☐ Claims ☐ Other:_____

4. **For the time period** _____/_____/_____ to _____/_____/_____

- Personal representatives will not be provided access to records of a minor for treatment if the minor was legally able to consent to themselves unless the minor signs below allowing access to this information.
- Access may be denied if the information is not part of the designated record set or if it is determined the access could endanger or harm the patient or others. Please refer to CHCO's Notice of Privacy Practices.

Signature _____ **Date** _____ **Signature of Patient** (when required) _____

☐ Parent or Personal Representative ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate

CHCO Health Information Management: 13123 E. 16th Ave, Box 150, Aurora, CO 80045 • Ph: 720-777-4259 • Fax: 720-777-7251

Children's Hospital Colorado
Affiliated with University of Colorado Anschutz Medical Campus

Place Patient Identification Label Here