1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Individual Request for Access to Protected Health Information

Patient's Full Name:________________________________ Birth date:____________________________

Address:____________________________________ Phone No.:__________________________

City/St/Zip:__________________________________ SSN: XXX-XX- _______________________

As provided by the Health Insurance Portability and Accountability Act (HIPAA) and applicable Michigan law, you have a right of access, with certain exceptions, to inspect and obtain a copy of your health information contained in a designated record set. This right does not apply to:

1. Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
2. Protected health information which is:
   a. Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 USC 263a, to the extent the provision of access to you would be prohibited by law;
   b. Psychotherapy notes.

As further provided by HIPAA and Michigan law, under certain circumstances, Sparrow Hospital (or __________________ ______________) may deny a patient (or other requestor) access to certain protected health information.

Specific type of information to which you request access:

☐ Sparrow ☐ Clinton ☐ Ionia
☐ Carson City ☐Sparrow Specialty Hospital

Date(s) of service: ______________________
Type(s) of service: ______________________
Request Date & Time:____________________

Description of information: ____

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Sparrow Health System (or ______________________________) will act on this request within 3 business days based on the date of the receipt of the request when the record is maintained electronically. An additional 30 days may be requested for information that is not complete, maintained or accessible to Sparrow Health System (or ____________________) on-site. You will be informed either of the acceptance of the request and be provided with the requested access, or you will receive a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed under applicable law.

If the same requested information is contained in more than one designated record set or at more than one location, and access is granted, Sparrow Health System (or ______________________) need only provide you with access to the requested information contained in one of the designated record sets.

Indicate the form and format in which you would like to receive your requested information. ☐ Paper copy ☐ Electronic copy (e.g., Computer disk) ☐ Other ____

Do you agree to receive a summary of the requested information in lieu of access or a copy? ☐ Yes ☐ No

Indicate the means by which you wish to inspect or obtain a copy of the requested information provide the necessary address or phone numbers at which you can be contacted. ☐ Fax ☐ Mail ☐ On-site inspection

Full Name: ____
Address: ____
Phone number: ____________________ Fax number: ____________________ Email: ____________________

If Sparrow Health System (or ____) cannot readily produce the information in the form or format you have requested, such information will be made available to you in a readable hard copy format or other format that you agree to.

Sparrow Health System (or ____) may impose a fee as authorized by law for various costs of complying with your request.

____
Printed name of patient or patient's representative

____ ________________________
Signature of patient or patient's representative Date Time

Complete only if patient or representative signs by use of a mark:

____
Printed name of witness

____ ________________________
Signature of witness Date Time

____
Printed name of witness

____ ________________________
Signature of witness Date Time

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

Sparrow Health System has verified the identification of ____ (patient's representative name) by ____ (type of verification, e.g., driver's license) and that in his/her capacity of ____(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

____ ________________________
Verification completed by (Caregiver name and signature) Date Time

REVIEW SECTION: (This section is to be completed by the reviewer)

Reviewer's Decision: Grant the Access Request _____ Deny the Access Request _____

Date received:	**Reviewed by:**
Department Director:	**Review Date:**

Reviewer's Comments:

____

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____ ________________________
Reviewer's signature Date Time

If your request for access to protected health information has been denied, you may have the right to request a reconsideration of the denial decision. You must submit your request for reconsideration in writing to Sparrow Healthy System Director of Health Information Management (or ______________________) at the address on the top of this form. You may obtain a *Request for Reconsideration of Denial of Access to Protected Health Information* form by calling 517-364-2276 (or ____________________________).

NOTE: As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to complain about our privacy policies, procedures or actions. Sparrow Health System will not engage in any discriminatory or other retaliatory behavior against you because of your complaint. All complaints must be submitted in writing to the Chief Privacy Officer at the address on the top of this form. A complaint form is available from the Chief Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services.