

Patient's Name: _____ Birth date: _____
Address: _____ Phone No.: _____
City /State/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; or
 - b. Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).
 - c. Psychotherapy Notes

As further provided by HIPAA and Michigan law, under certain circumstances Sparrow Health System (or _____) may deny patient (or other requestor) access to certain protected health information.

Specific type of information to which you request access: _____ Date(s) of service: _____
Type(s) of service: _____
Time: _____

Sparrow Clinton Ionia Sparrow Specialty Hospital

Description of information: _____

Sparrow Health System (or _____) will act on this request within 30 business days of the date listed above or, within an additional 30 days if the requested information is not 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? Yes No

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

Electronic copy (e.g., computer disk) Other _____

Full Name: _____
Address: _____
Phone number: _____ Fax number: _____

Sparrow
Lansing, MI

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**INDIVIDUAL REQUEST FOR ACCESS TO
PROTECTED HEALTH INFORMATION**

If Sparrow Health System (or _____) cannot readily produce the information in the 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 of as authorized by law to cover the 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 patient or patient's representative

Date Time

[If the above signature is that of a patient's representative, Sparrow Health System 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 designated personal representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by (Associate 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:

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 Health 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.

