

**RUSH OAK PARK HOSPITAL
HIPAA PRIVACY PATIENT RIGHTS REQUEST FORM**

PATIENT RIGHT REQUESTED: (check the patient right(s) you want to exercise)

- Access Medical Record
- Restriction Request
- Amendment Request
- Confidential Communications **
- Accounting of Disclosures

Please provide us with the following information:

Patient's Name:	Telephone Number:
Address:	
City:	State:
Social Security Number:	Date of Birth:

ACCESSING YOUR MEDICAL RECORD

You have the right to inspect and obtain a copy of your protected health information in the medical record that Rush Oak Park Hospital maintains. To exercise your right of access, please complete the following:

Type of access requested	Select information to be copied or inspected
<ul style="list-style-type: none"> <input type="radio"/> Copies of the record <input type="radio"/> Inspection of the record 	<ul style="list-style-type: none"> <input type="radio"/> Abstract/Pertinent Information <input type="radio"/> Operative/Procedure Report <input type="radio"/> Cardiac Studies <input type="radio"/> Nursing Notes <input type="radio"/> Imaging/Radiology <input type="radio"/> Other: _____ _____
	<ul style="list-style-type: none"> <input type="radio"/> Emergency Room <input type="radio"/> Lab <input type="radio"/> MD Progress Notes <input type="radio"/> Entire Medical Record <input type="radio"/> Consultation

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location. ****This request is limited to the department in which you make the request.** To exercise this right, please indicate which department and complete below: _____

DEPARTMENT

Describe the protected health information you want to make subject to confidential communication:

- lab results
- treatment information
- billing
- Other: (please explain): _____

How do you wish for this department to communicate with you?

- Phone number: _____
- E-mail Address: _____
- Fax number: _____
- Other: (please explain): _____

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RESTRICTION REQUEST

You have the right to request that Rush Oak Park Hospital restrict the use or disclosure of your protected health information, including for treatment, payment or our health care operations. Rush Oak Park Hospital is not legally obligated to honor your request. The Rush Oak Park Hospital Privacy Office administers ALL restriction requests. To exercise your right to request restriction on the use or disclosure of your protected health information, please complete the following:

Specify the protected health information, the use or disclosure of which you want to restrict:

- lab results
- treatment information
- billing
- Other: (please explain): _____

State the restriction you want to apply to that protected health information:

ACCOUNTING OF DISCLOSURES

You have the right to an accounting of the disclosures Rush Oak Park Hospital or its business associates have made of your protected health information. You are entitled to one free disclosure accounting every 12 months. Rush Oak Park Hospital will charge you \$ _____ for each additional disclosure accounting you request during the same 12-month period. To receive an accounting of disclosures please provide the dates of disclosures you want us to account for:

From: ____/____/____ **To:** ____/____/____

AMENDMENT REQUEST

You have the right to request that Rush Oak Park Hospital change or amend your protected health information in the medical record that Rush Oak Park Hospital maintains. Rush Oak Park Hospital may deny your request in certain circumstances. The Privacy Office administers ALL amendment requests. To exercise your right to request amendment, please complete the following:

Specify the records you wish to amend and the amendments you wish to make:

- lab results
- treatment information
- billing
- Other: (please explain): _____

State the reasons for the amendment request: _____

PATIENT'S SIGNATURE: _____ **Date:** _____

If this request is by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Personal Representative's Signature: _____

Relationship to Patient: _____