

Winneshiek Medical Center
REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Date of Request: ____/____/____

Medical Record #: _____

Name: _____

Date of Birth: _____

I request that Winneshiek Medical Center provide me with access to my Protected Health Information as specified below:

Medical Records dated ____/____/____ through ____/____/____

Please specify type of information _____

Type of Access Requested

- Copies of my health information

Please mail the information to:

- Inspection of my health information – Please contact Health Information Management at (563) 387-3100 to arrange a mutually convenient time for inspection.

Signature of Patient or Patient's Authorized Representative

____/____/____
Date

If signed by the patient's Representative, please print the name and describe the relationship to the patient:

Name

Relationship

Medical Center use only:

____ Approve access requested above.

____ Deny access requested above. (Complete reverse side of form.)

Name of Medical Center Staff Processing Request

____/____/____
Date

Title

Identification verified by _____

Date ____/____/____

Method:

- Picture ID
- Personally know individual



Winneshiek Medical Center

DENIAL OF ACCESS TO PROTECTED HEALTH INFORMATION

Access to Protected Health Information was denied for the following reason:

- The Protected Health Information requested is not part of the medical record or billing record that the medical center maintains.
- Winneshiek Medical Center does not possess the Protected Health Information requested. The information may be requested from _____.
- A licensed healthcare professional has determined that the access requested is likely to endanger your life or physical safety.
- A licensed healthcare professional has determined that the access requested is likely to endanger another person's life or physical safety.
- The information makes reference to another person (other than a healthcare provider) and a licensed healthcare professional has determined that the access requested is likely to cause substantial harm to the person.
- As a personal representative, a licensed healthcare professional has determined that access to the requested information is likely to cause substantial harm to the patient or another person.

You may request access to any other Protected Health Information to which access has not been denied. You have the right to request a review of the denial. The person who reviews the denial will not be involved in the original denial. You have the right to file a complaint with the medical center. If you wish to have the denial reviewed or to file a complaint, contact Winneshiek Medical Center's Privacy Officer at ext. 3106 or (563) 387-3106.