Taylor Health and Wellness Center
Southwest Missouri State University
901 S. National Avenue, Springfield, MO 65804-0094
Phone: (417) 836-4000 Fax: (417) 836-4133 http://health.smsu.edu

ACCESS REQUEST FORM
FOR PROTECTED HEALTH INFORMATION

Instructions: Sections 1-3 must be completed. Please print all information except for signatures.

Section 1: **PATIENT IDENTIFICATION** Print Name:_____
Street Address, City, State & Zip Code:_____
Patient's Social Security Number:_____ Date of Birth:_____

Section 2: **RIGHT TO ACCESS**

I understand I have the right to inspect or obtain a copy of my protected health information maintained by Taylor Health and Wellness Center (Taylor). I understand that Taylor will make every reasonable effort to provide me access to my protected health information. Taylor may provide a summary, in lieu of providing access to the protected health information requested, or may provide an explanation of the protected health information to which access has been provided, if I agree in advance to the summary, and if I agree in advance to the fees imposed for such summary. The fee for copying my protected health information or providing a summary to me is $_____.

Please initial all appropriate boxes:

☐ Pursuant to that right, I hereby request Taylor to copy the following records and mail them to me at: _____
_____
Description of records to be copied: _____
_____

☐ Pursuant to that right, I hereby request Taylor to allow me to inspect my medical records at Taylor. I will contact the Privacy Officer at (417) 836-4000 to arrange a mutually convenient time for inspection.

Section 3: **RIGHT OF DENIAL**

I understand Taylor Health and Wellness Center has the right to deny my request for access to the extent allowed by law. I also understand that Taylor Health and Wellness Center may deny my request for access if it is not in writing or does not include a reason to support the request.

_____ _____
Signature of Patient Date
(If under 18 years of age-Parent, Legal Guardian, or Legal Representative)

If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1:_____

FOR OFFICIAL USE ONLY

Section 4: **RESPONSE TO REQUEST** Date Received:_____ Initials:_____

Restriction has been: ☐ GRANTED ☐ DENIED with Right for Review
☐ DENIED with **no** Right for Review

If denied, please explain reason for denial: _____
_____
Other Comments: _____
_____

_____ _____
Signature of Privacy Officer Date

A copy of this form will be filed in the above-named patient's PHI.