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REQUEST FOR PATIENT ACCESS TO HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

I hereby request access to health information for:	
Name: Date of Birth:	
Mailing Address: SCOPE OF ACCESS REQUESTED I would like access to: ☐ All records for Medical and Behavioral Health ☐ Dental OR ☐ The portion of the records concerning: (Specify type of disease, labs, dates of treatment, accident, or other portion of records in which you are interested.)	
Patient Signature: D	Pate:Telephone:
If not signed by the patient, please indicate your relationship: □ parent or guardian of minor patient □ other (specify) □ guardian or conservator of an incompetent patient □ beneficiary or personal representative of deceased patient	
☐ Your request is granted. ☐ You may come in and inspect the records on	☐ Your request is denied. ☐ This medical practice does not have the records requested.
(date and time within thirty (30) working days after receipt of request).	 ☐ The records requested were compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding. ☐ You are not allowed by law to access these records without the patient's consent.
☐ We will send the copies you requested within thirty (30) days.	
Privacy Officer: Helen Royal 970-668-6883	without the patient's consent.
NOTE: If you believe your rights have been violated, you may file a complaint with this medical practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to our Privacy Officer at the address listed at the top of this form. You will not be penalized for filing a complaint. A complaint form is available from the Privacy Official listed above. Interpreter's Statement	
I have orally translated and explained the contents of the information on this form to the patient in a language they understand. To the best of my knowledge and belief, they understand this explanation and voluntarily consent to the release of records determined above. Interpreter's Signature:	
** SCCC will respond to your request within 30 business days. **	
Rendering Provider signature:	Date:

_ Date: _

Request completed by: __