Facility Name or Logo: On-Site Solutions Physical Therapy	*Protected Health Information Access Request Form*	Revision Number: 1-2024

Date Received	
Initials of HIPAA Compliance Officer	

Patient to complete the following information:

Patient Name: _____

Date: _____

Request

I hereby request that the On-Site Solutions Physical Therapy (hereafter: "Facility") provide me with access to my Protected Health Information as checked below. (Check all that apply):

☐The entire health record (all information) to the above-named requestor	
☐Activity documentation	☐Minimum Data Set
☐Admission/re-admission documentation	☐Medication and treatment records
☐Advance directives	☐Nursing documentation/progress notes
☐Assessments, flow-sheets	☐Progress notes
☐Care plan	☐Reports from lab, x-ray, and other diagnostic ☐tests
☐Informed consent	☐Face sheet
☐History, exams and other records	
☐Other: (Describe as specifically as possible)	

Protected Health Information Access Request Form

I request access to my health information as indicated above covering the dates:

From date		To date	

Type of access requested:

- ☐Inspection of requested information at the facility
- ☐Copies of requested information maintained by the facility

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

Protected Health Information Access Request Form

Facility to complete the following

FACILITY RESPONSE

The request for access or copy is:

☐Accepted ☐Denied

If denied, check the reasons for denial:

- ☐PHI is not part of the patient's Designated Record Set
- ☐Federal law forbids making the requested information available to the patient for inspection (e.g., CLIA or Privacy Act of 1974)
- ☐The requested information is psychotherapy notes
- ☐The requested information has been compiled for legal proceeding
- ☐The requested information was obtained under promise of confidentiality and access would be reasonably likely to reveal the source of the information
- ☐The requested information is temporarily unavailable because the individual is a research participant
- ☐Licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others
- ☐Licensed health care provider has determined that the requested information identifies a third person who may be physically, emotionally, or psychologically harmed if access to the information is granted
- ☐Licensed health care provider has determined that access to the requested information by the patient's personal representative could result in harm to the individual
- ☐We are acting under the direction of a correctional institution and letting the inmate access or obtain a copy of the requested information would jeopardize the health, safety, security, custody, or rehabilitation of another person at the correctional institution
- ☐The requested information is not maintained by our Facility

Protected Health Information Access Request Form

RIGHT TO REVIEW

- ☐Yes
- ☐No (contact the Facility HIPAA Compliance Officer at hipaa@onsitesolutionspt.com with any questions)

You have the right to file a complaint with our Facility and the Secretary of Health and Human Services, Contact the Facility HIPAA Compliance Officer for additional information.

Completed by	
Signature of Facility Representative	
Date	