v01.2023

Philadelphia FIGHT Community Health Centers

PATIENT REQUEST FOR ACCESS TO INFORMATION

A FIGHT Patient or legally authorized representative has a right to access the Patient's protected health information ("**PHI**"), which includes a right to inspect or copy the Patient's PHI, or both.

Under some circumstances, such as increased risk of harm or injury, FIGHT may deny the Patient's request for access to PHI. FIGHT will evaluate the Patient's request for access upon receipt and notify the Patient of FIGHT's decision within thirty (30) days of receipt of the request. If FIGHT approves the Patient's request, FIGHT will provide the PHI within thirty (30) days, or within sixty (60) days if an extension is necessary. FIGHT will charge the Patient for the following costs related to fulfilling the request: (1) labor for copying the requested PHI, whether on paper or electronic form, consistent with then current Pennsylvania law; (2) supplies for creating the paper copy or electronic media; (3) postage, when the Patient requests that FIGHT mail the information; and (4) preparation of an explanation or summary of the PHI, if agreed to by the Individual. Costs will be submitted to the Patient after FIGHT fulfills the request.

Patient First and Last Name:_____ DOB:_____

Would you like a copy of your entire medical record (Check One)? ☐ YES ☐ NO
Would you like a copy of your entire billing record (Check One)? ☐ YES ☐ NO

If NO, describe the specific information you are requesting, including dates, specific tests, or any other indications of the specific information you desire:_____

Do you wish to (Check One):

☐ Receive a copy ☐ Make an appointment to read the requested information

If you would like to receive a copy of the information, what format would you like it in (Check One)?

☐ Paper Copies ☐ Electronic Format. Specify: _____

Instructions regarding copies:

☐ I will pick the copies ☐ Please mail the copies to _____

at the following address: _____

_____

This Request made by (Check One):

☐ SELF Request - Adult or Adolescent Patient 13 years of age or older

☐ Legal Guardian/Parent Request
For: (Check One): ☐ Pediatric Patient aged 0-12 ☐ Adolescent Patient aged 13-17
Guardian/Parent Name:_____ Guardian/Parent DOB:_____

☐ Patient's Legally Authorized Representative Request - complete below
Representative Name:_____ Representative DOB: _____
Description of Legal Authority to act for the Patient: _____

_____ _____
Signature of patient or patient's Legally Authorized Representative Date
(Form MUST be completed before signing.)

FOR INTERNAL FIGHT USE ONLY

☐ Approved ☐Denied- If the request was denied staff must email this request form to FIGHT's Privacy Officer at privacy@fight.org, within twenty (20) days of request, for Review.

This form can be submitted in person at any Philadelphia FIGHT Health Center, via email to privacy@fight.org, via fax 215-732-1145 Attention: Privacy Officer, or via mail Philadelphia FIGHT Privacy Officer, 1233 Locust St. 5th Floor, Philadelphia PA 19107.