

THE UNIVERSITY OF TEXAS AT DALLAS
CALLIER CENTER FOR COMMUNICATION DISORDERS

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Requestor: _____ Daytime Phone # _____

Address: _____

DOB: _____ Email address: _____

(If you are requesting this information as a Personal Representative, you *must* provide your contact phone number, street address, & e-mail address below.)

I request access to medical information maintained by or for the Callier Center about me

I request access to the following medical information (please specify the exact information to be disclosed, including, if applicable, dates of service):

- My complete medical record (Note: May include HIV, mental health or drug and alcohol treatment or other sensitive records)
- Other (list types of records requested, may include dates of service if desired):

I request access to the medical information in the following form:

- On-site access to the records
- Copies delivered to me by mail to the following address:

Address: _____
(street) (city) (state) (zip)

- Copies delivered to someone else by mail to the following address:

Address: _____
(street) (city) (state) (zip)

- Copies faxed to me at the following number: _____

- Other: _____

Please note; if you request records to be sent via email, we cannot guarantee that they will be secure or confidential during transit or in the email account to which they are sent. In addition, we assume no responsibility for the security or confidentiality of records provided to a third party at your request.

I understand that UT Dallas may charge a fee for the costs of copying, mailing, or other supplies associated with this request.

I further understand that UT Dallas may, under applicable law, deny my request to access my medical records in certain limited circumstances. In some cases, if I am denied access to my medical information, I may request that the denial be reviewed, in which case a licensed health care professional chosen by the Callier Center will review my request and the denial. The person conducting the review will not be the person who initially denied the request. The Callier Center will comply with the outcome of the review.

Signature: _____ Date: _____

If you sign this request as the Legal Representative of the individual, you *must* provide adequate documentation of your authority to serve as the person's representative *and* sign below:

Printed name of legal representative: _____

Representative's authority to act for individual: _____

For Callier Center Use Only

Person processing request for access: _____

Date request received: _____

Any requested PHI maintained off-site? Yes No

Location: _____

Deadline to grant/deny requested access: _____

Was there an extension of the deadline?

No

Yes: Reason: _____

Date written notification given: _____

New deadline to grant/deny access: _____

Access: Granted Denied Date individual notified: _____

If granted:

Date access granted: _____

How access provided: _____

Fee charged: _____

If denied, reason _____

If denied for reviewable grounds:

Did individual request review of denial?

No

Yes