Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Initials of Privacy Officer/Designee:\_\_\_\_

**SECTION A: Patient to complete the following information**

Requestor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUEST:**

I request that The Jackson Laboratory provide me with access to my Protected Health Information as indicated below. **(Check all that apply)**:

\_\_\_ The entire Medical Record (all information) \_\_\_ Laboratory reports and other diagnostic tests

\_\_\_ Informed Consent \_\_\_ Face Sheet

\_\_\_ Clinical Result Report: (specify test(s)) \_\_\_ Complete Molecular Profile: (specify test(s)):
 \_\_\_ Other (describe in detail)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request access to my health information covering the dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

### Type of Access Requested

\_\_\_\_\_ Inspection of requested information or \_\_\_\_\_ Copies of requested information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

**SECTION B:** **The JLCE to complete this section**

**Request for access or copy is** (CLD or HIPPA Privacy Officer)\_\_\_\_\_ Accepted \_\_\_\_\_ Denied

If denied, check the reasons for denial:

\_\_\_\_\_PHI is not part of the patient’s Designated Record Set

\_\_\_\_\_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 The Jackson Laboratory

**RIGHT TO REVIEW:**

\_\_\_\_\_Yes

\_\_\_\_\_No – Contact the JLCE HIPAA Privacy Officer with any questions.

You have a right to file a complaint with The Jackson Laboratory and may do so by contacting our HIPAA Privacy Officer at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(insert phone number). You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. Contact our HIPAA Privacy Officer or see our Notice of Privacy Practices for additional information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Privacy Officer Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name

If your request to copy the requested information has been granted, you will be charged a reasonable fee for photocopying and mailing.

**Distribution of copies: Original to patient’s medical record, copy to patient.**