Harris County ESD 11
Patient Request for Access to Protected Health Information

Patient Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Date of Birth: _____

Right to Request Access to Your PHI and Our Duties:

You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information ("PHI") that HCESD 11 maintain in a designated record set. If HCESD 11 maintains your PHI in electronic format, then you also have a right to obtain a copy of that information electronically. In addition, you may request that HCESD 11 transmit a copy of your PHI directly to another person and HCESD 11 will honor that request when required to do so. Requests to transmit PHI to another party must be in writing, signed by you (or your representative), and clearly identify the designated person to whom the PHI should be sent, and where the PHI should be sent.

Generally, HCESD 11 will provide you (or your authorized representative) access to your PHI within thirty (30) days of your request. HCESD 11 may verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, legal authority to act on behalf of the patient (such as a power of attorney) or other information necessary to verify that the requestor has the right to access PHI. In limited circumstances, HCESD 11 may deny you access to your PHI, and you may appeal certain types of denials. HCESD 11 may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

Request for Access to PHI:

Below, please describe the PHI that you are requesting access to with as much specificity as possible. Specify dates of service and other details that will allow HCESD 11 to accurately and completely fulfill your request.

_____

_____

_____

Specify How You Would Like HCESD 11 to Provide Access:

Please check all that apply and fill out the requested information, where indicated.

⬜ Please provide me with a copy of my PHI

⬜ Mail. Please send a copy of my PHI to me at the following address:

Street: _____

City: _____ State: _____ Zip Code: _____

Format (paper copy, digital copy on a disk, etc.): _____

⬜ Email. Please email a copy of my PHI to the following email address in the specified format:

Email address: _____

Format (PDF, Word, etc.): _____

⬜ Please transmit a copy of my PHI to the following party at the following mailing address or email address in the specified format:

Designated Party: _____
Street: _____
City: _____ State: _____ Zip Code: _____
Email address: _____
Format (PDF, Word, etc.): _____

⬜ I would like to inspect a copy of my PHI at HCESD 11's place of business (HCEMS will arrange a convenient time and place for you to inspect a copy of your PHI during normal business hours)

Signature of Requestor: _____ ***Request Date:*** _____

Requestor Information (if requestor is different from patient):

Name: _____
Relationship to Patient (parent, legal guardian, etc.): _____
Street Address: _____
City: _____ State: _____ Zip Code: _____