Amherst H. Wilder Foundation

INDIVIDUAL REQUEST FORM

Side A

Client Last Name:	
Client First Name:	
Date of Birth:	
Client #:	

ACCESS

REQUEST FOR ACCESS TO MEDICAL RECORD:
NOTE: Fees for copying, postage, or summary preparation may be imposed by Wilder in order for us to accommodate your request.

I request access to my medical record.

I want to: ☐ obtain a copy of the following:

☐ Most Recent Diagnostic Assessment ☐ Plus the Last Three Progress Notes

☐ Records from ________ to ________________________________

☐ Entire Record

☐ Other (specify): ________________________________

AMEND

REQUEST TO AMEND MEDICAL RECORD:

I request that Wilder amend my medical record as follows (please state reason for request and specify the amendment):

____

I further request that Wilder share the amendment with the following people and/or organizations, and I agree to have Wilder notify the same:

____

WILDER'S RESPONSE within 30 days of receipt:

☐ Amendment accepted. ☐ Request denied. See attached letter for explanation and your review rights.

ACCOUNTING

REQUEST FOR ACCOUNTING OF DISCLOSURES OF MEDICAL RECORD:
Note: The first accounting to an individual within any 12-month period will be provided without charge. A fee may be charged for each subsequent request for an accounting by the same individual within the 12-month period.

I request that Wilder provide me with an accounting of disclosures of my medical record made by Wilder for the following timeframe: ______________________ [Note: Timeframe must be for disclosures made within the last six years of the date of request.]

WILDER'S RESPONSE within 60 days of receipt:

☐ Extension requested (30 days maximum). Reason for the delay: ______________ Date for completion: ________

☐ Accounting enclosed per your request.

SIDE A SIGNATURE

Client Signature	Personal/Legal Representative*, Parent or Guardian
Print Name	Print Name
Address 1:	Address 1:
Address 2:	Address 2:
Phone:	Phone:
Date:	Date:

***If you are signing as a personal representative for an individual, you must complete and sign an acknowledgement form.**

Amherst H. Wilder Foundation

INDIVIDUAL REQUEST FORM

Side B

Client Last Name: ______________________
Client First Name: ______________________
Date of Birth: ______________________
Client #: ______________________

REQUEST FOR CONFIDENTIAL COMMUNICATION RELATED TO MEDICAL INFORMATION:
Note: A fee may be imposed by Wilder in order for us to accommodate your request.

I request that I receive confidential communications regarding my medical information by alternate means: ☐ via fax at ______________________ (fax number) ☐ via email at ______________________ (email address) ☐ other means (please specify): ______________________

Or by alternate location. Please mail my communications to: ______________________

____

Wilder will accommodate all reasonable requests.

RESTRICTIONS

REQUEST TO LIMIT THE USE OR DISCLOSURE OF MEDICAL RECORD:

I request that Wilder limits how:

☐ Wilder uses or discloses information in my medical record to carry out treatment, payment, or healthcare operations
☐ Wilder discloses information in my medical record for involvement in my care and notification purposes
☐ Wilder discloses information in my medical record to my health plan. I understand that in order to make this request, I must pay in full, and in advance, for the services that I don't want disclosed to my health plan.

Specifically, I request that Wilder restrict the following use or disclosure:

____

____

For the following reason(s) (this section not required for restriction on disclosure to health plan):

____

____

Note: A restriction can be terminated by the individual or by Wilder (except limits on disclosures to health plans) at any time. The date of the termination by either party will be documented by Wilder and added to the individual's file. The termination is only effective with respect to the information created or received after the documented date of termination. **Termination of the restriction must be done in writing**.

☐ I request that Wilder terminate the above restriction. ______________________ (Name) ______________________ (Date)

WILDER'S RESPONSE:

☐ Wilder agrees to the above restriction and will document and abide by the requested restriction except in situations as outlined in the Privacy Rule.
☐ Wilder denies this request as provide for in 45 C.F.R. 164.522(a)(1)(ii).

TERMINATION OF RESTRICTION: **[FOR INTERNAL USE ONLY]**

Wilder requested termination of restriction on ______________ (date).

Although not required by HIPAA for an effective termination, individual agreed ☐ in writing, or ☐ orally on: ______________ (date).

The individual requested termination of restriction on ______________ (date).

Note: The termination is only effective with respect to the protected health information created or received after same date.

SIDE A SIGNATURE

______________________ Client Signature

______________________ Personal/Legal Representative*, Parent or Guardian

______________________ Print Name

______________________ Print Name

Address 1: ______________________
Address 2: ______________________
Phone: ______________________
Date: ______________________

Address 1: ______________________
Address 2: ______________________
Phone: ______________________
Date: ______________________

Amherst H. Wilder Foundation

INDIVIDUAL REQUEST FORM

Personal Representative Acknowledgement

Client Last Name: ____________________

Client First Name: ____________________

Date of Birth: ____________________

Client #: ____________________

If you are signing as a personal/legal representative for an individual, read and sign below:

I, ______, ____________________________ hereby certify and attest that I am the duly authorized personal representative of ____ and that I have the lawful authority to make this request on behalf of such individual.

____
Signature

____
Print Name

____
Date