University of Nebraska Lincoln

UNIVERSITY HEALTH CENTER

Request for Access to Protected Health Information Form 27.35a

Please complete this entire form to request inspection or copies of your personal health information maintained by the University Health Center (UHC). We will notify you when your request has been processed and the records are ready for inspection or have been copied and the fee for your request. There are certain circumstances in which your request may be denied. If your request has been denied, you will be notified of the denial and the reasons why. UHC cannot process your request if this form is not complete.

Patient Name (Please print clearly): _____ D.O.B: _____

Current Address: _____

Phone No.: _____ NU ID No or Acct. No.: _____

Dates of service or time period of records requested: _____(State a specific time period or "all")

Please check below the information which you would like to review (you may check more than one box):

☐ Clinic progress notes ☐ Laboratory results ☐ History & Physical ☐ Dietician notes (after Dec 2011) ☐ X-ray reports
☐ Physical Therapy ☐ Immunization records ☐ Allergy records ☐ Dental treatment records ☐ Dental X-rays
☐ Dermatology records ☐ Billing record ☐ Other (be specific): _____

Please designate the method of review:

Mail

☐ Receive copy by regular mail at the following address: _____
I understand that I will be charged a fee as follows: 1-15 pages $15.00; 16-30 pages $25.00; 30+ pages $35.00.

Inspection Only

☐ Inspect the information at UHC during normal business hours Monday – Friday 8:00 AM to 5:00 PM.

Inspection and Copy

☐ Inspect the information at UHC and receive a copy at the time of inspection. I understand I will be charged a fee as follows: 1-15 pages $15.00; 16-30 pages $25.00; 30+ pages $35.00.

Electronic Copy

Format Request: ☐ PDF
☐ Other format (please specify) _____

Media: ☐ Transmitted to me at the following e-mail address: _____

I UNDERSTAND THE RISKS IN RECEIVING MY PROTECTED HEALTH INFORMATION VIA UNENCRYPTED E-MAIL AND THAT IT MAY BE READ BY A THIRD PARTY.

☐ Mailed on a CD ROM to me at the following address:_____

_____

☐ Other media request (please specify):_____

I understand that I will be charged a fee of at least $15.00 for preparing the electronic copy.

_____ _____
Signature of patient or patient's personal representative Date

_____
Authority of personal representative

We will not process this request unless it is signed by you or your representative.