

Request Access to PHI Retained in the Designated Record Set

Name of Patient _____ YNHH MRN# _____
 Date of Birth _____ Daytime Phone # _____
 Address _____ Evening Phone # _____
 City _____ State _____ Zip Code _____

Information Release Requested On: _____ - _____ - _____ Information Access Type: Inspection Copy
(month) (day) (year)

Information to be Released (Please describe): _____
 Information to be Released to: _____

Self (patient) Other (Please specify):
 _____ Mail Name: _____
 _____ Pick up in person Address: _____
 Contact at _____ Relationship to Patient: _____
 _____ Mail _____ Pick up in person-contact at _____

YSM Staff: Authorization Required? Yes No Obtained? Yes No
 Date Records Released: _____ - _____ - _____

I understand that I will receive a copy of this form and that my request will be processed within thirty (30) days or I will be informed of the need for an extension of not more than thirty (30) additional days to process the request.
 I understand if I checked the "Inspection" box above that I will need to schedule an appointment with my healthcare provider to review ONLY the information specified to be released.

I understand if I checked the "Copy" box above that I will be responsible for paying a reasonable cost-based fee for supplies, labor, postage and copying in accordance with State of Connecticut laws, and that the requested information will be mailed to me or someone else I designate above via US postal mail at the address indicated above, or I may arrange to pick up the records myself or by the person I designate above.

I understand that this request for release of information may be denied or reduced and only portions released. If so, I have the right to request a review of this decision by another licensed health care professional that Yale designates by submitting my request in writing to:

Deputy Privacy Officer
 Yale School of Medicine
 300 George Street, 6th Floor
 P.O. Box 9805
 New Haven, CT 06535-9805

I have the right to file a written complaint concerning any final denial of my request for access within 180 days of my receipt of this denial to:

Privacy Officer
 Yale University
 P.O. Box 208337
 New Haven, CT 06520-8337

Or you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Contact our Privacy Office at 203-436-3650 to obtain this address.

 Signature of Patient Date OR Parent/Legal Guardian/Authorized Person Date

 Relationship to Patient