

RUSH UNIVERSITY MEDICAL CENTER
**HIPAA PRIVACY PATIENT RIGHTS
REQUEST FORM**

Patient Rights-P
HIPAA Privacy Patient Rights



IDN13150017

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

INSTRUCTIONS: As a patient, you have the right to access information in your medical record and to make requests related to this information. The patient rights available to you are listed below – please check which of these rights you would like to use. (Note: If a personal representative is making this request, please attach certifying documentation of your status as the personal representative, such as a Power of Attorney or Guardianship papers).

____ Confidential Communications ____ Restriction Request ____ Accounting of Disclosures ____ Amendment Request

When completed, please return this form to: **Rush University Medical Center, ATTN: Privacy and Security Office, 707 South Wood St., Suite 317, Chicago, IL 60612-3833, Telephone: (312) 942-4416, Fax: (312) 942-6875**

NOTE: Please contact the Rush Health Information Management Office at 312-942-7262 (phone)/312-942-2264 (FAX) in order to inspect your record on-site at our facilities, or, to request a copy of your medical record. You may also make a request by sending a Rush Form MR1928 to: Rush University Medical Center, ATTN: Health Information Management Office, 1611 West Harrison St., L1, Suite 001, Chicago, IL 60612.

SECTION A – PERSONAL INFORMATION

Patient Information – please provide us with the following information about the patient:

_____ Last Name	_____ First Name	_____ Middle Name
_____ Street Address	_____ City	_____ State
_____ Zip Code	_____ SSN	_____ Date of Birth
_____ Patient Signature	_____ Date of Request	

Personal Representative – if you are the patient's personal representative, please provide your information, below:

_____ Last Name	_____ First Name	_____ Middle Name
_____ Street Address	_____ City	_____ State
_____ Zip Code	_____ SSN	_____ Date of Birth
_____ Personal Representative Signature	_____ Date of Request	_____ Relationship to Patient

SECTION B – PATIENT RIGHTS

____ **CONFIDENTIAL COMMUNICATIONS (check if you are exercising this right)**

You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location. (Note: This request is limited to the department in which you make the request). To exercise this right, please indicate which department and complete below:

Department Name

Department Location

Identify the protected health information you want to make subject to confidential communication:

____ Lab results ____ Billing

____ Treatment information ____ Other: (please explain): _____

How do you wish for this department to communicate with you? ____ Phone ____ Postal Mail

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RESTRICTION REQUEST (check if you are exercising this right)

You have the right to request that Rush restrict the use or disclosure of your protected health information, including for treatment, payment or our health care operations. Please specify the type of protected health information you would like restricted and the dates of the information:

Lab results Billing
 Treatment information Other: (please explain): _____

Dates of Information _____

State the restriction you want to apply to that protected health information:

ACCOUNTING OF DISCLOSURES (check if you are exercising this right)

You have the right to an accounting of the disclosures Rush or its business associates have made of your protected health information. You are entitled to one free disclosure accounting every 12 months. Rush will charge you on a per page basis \$ _____ for each additional disclosure accounting you request during the same 12-month period. To receive an accounting of disclosures please provide the dates of disclosures you want us to account for:

From: ____/____/____ to: ____/____/____

AMENDMENT REQUEST (check if you are exercising this right)

You have the right to request that Rush change or amend your protected health information in the medical record that Rush maintains. Rush may approve or not approve the request under certain circumstances. Specify the records you wish to amend and the amendments you wish to make:

Lab results Billing
 Treatment information Other: (please explain): _____

State the reasons for the amendment request:
