Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH

HIPAA PRIVACY PATIENT RIGHTS REQUEST FORM

Patient Rights-P
HIPAA Privacy Patient Rights

IDN13150017

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 ____ 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. A Request to Restrict the use or disclosure of a medical record must be done using Rush Form MR9518. Questions about this form should be addressed to the Privacy Office.**

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, 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	XXX-XX- _____ Last 4 SSN	Date of Birth
Patient Signature	Date of Request	Phone Number

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	Phone Number	Date of Birth
Personal Representative Signature	Date of Request	Relationship to Patient

RUSH

HIPAA PRIVACY PATIENT RIGHTS REQUEST FORM

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

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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_____ **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:

_____