



Request to Access Protected Health Information

Description: This form allows an individual to request access to or obtain a copy of a record set maintained by Travis County.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to inspect or obtain a copy of protected health information that Travis County maintains in a designated record set. To request access to your protected health information, complete and submit this form to:

HIPAA Compliance and Privacy Office
700 Lavaca, Suite 400
Austin Texas 78701

You may also email a scanned form to:
privacy@traviscountytx.gov

Please note that Travis County may deny your request for access under certain circumstances, and that a reasonable fee will be charged for copying (including labor and supplies), postage (provided that the records are mailed to you), and the preparation of any summary or explanation of records that you request.

Part I: Requestor's Identity

Name: _____

Date of Birth: _____

Address: _____

Street

City

State

Zip Code

Telephone number: _____ Email Address: _____

If you are requesting access on someone else's behalf, provide the name and address of the person on whose behalf you are requesting and describe and provide proof* of your legal relationship with the individual. Recognized legal relationships include: parent of minor child, legal guardian, power of attorney, or executor.

Name: _____

Address: _____

Street

City

State

Zip Code

Relationship to Individual: _____

**Travis County will accept documentation such as an executed will, power of attorney, or court order. You must also furnish a valid government issued picture ID.*

Part II: Request

Travis County component* (Department, Division, or Program) which maintains your record(s):

** A list of the covered components within Travis County is available from the HIPAA Compliance and Privacy Officer or on the Travis County web page <https://www.traviscountytx.gov/hipaa>. Please note that this request applies only to the component that you list above. If you wish to request access to the protected health information maintained by other components, you must complete a new form for each component.

How would you like to access your record(s)?

- Inspect in person
- Receive a copy of the records via:
 - Electronic Transmission
 - U.S. Mail
 - Portable Media (e.g., CD-ROM, USB)
 - Other: _____
- Both

Record(s) to be accessed or copied:

- Entire Record
- Clinic/outpatient Record
- Statement of Charges
- History/Physical Exam
- Past/Present Medications
- Other: _____
- Billing/Claims Submitted
- Discharge Summary

Do you want Travis County to prepare a summary or explanation of the requested record(s)?

- Yes
- No

Part III: Important Information

- Travis County maintains many of its records in electronic form; however, some records may only be maintained in hard copy form. In the event that Travis County does not maintain and cannot readily produce the requested records in electronic format, Travis County will provide the records in a readable hard copy form. A copy of these records will be sent to requestor via U.S. Mail at the address set forth below.
- Travis County will act on most requests within 60 days after the date it was received. If Travis County cannot act on your request within this timeframe, Travis County will notify you in writing of the reason for the delay and the date by which the request will be completed.
- Travis County will inform you of its decision to grant or deny your request.
- If Travis County denies your request, Travis County will notify you in writing and will explain what rights, if any, you have to appeal the denial.

Part IV: Acknowledgement

By signing this form, I am acknowledging that Travis County may charge me a reasonable, cost-based fee for copying, postage, and the preparation of any explanation or summary that I have requested.

Signature of Requestor

Date

Please provide the address where we should send written correspondence about this matter.

Mailing Address: _____
Street City State Zip Code

Email Address: _____

OFFICE USE ONLY

<p>Access is:</p> <p><input type="checkbox"/> Accepted—in full</p> <p><input type="checkbox"/> Accepted—in part</p> <p><input type="checkbox"/> Denied –reviewable</p> <p><input type="checkbox"/> Denied-unreviewable</p>	<p>If the request was <u>denied</u>, for what reason?</p> <p>_____</p> <p>_____</p>
<p>Date notification sent to individual: _____</p>	
<p>Request for review submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p>	
<p>HIPAA Compliance and Privacy Officer Signature: _____</p>	
<p>Date Received: _____ Received by: _____ Title: _____</p> <p>Date Forwarded to Privacy Liaison: _____</p>	
<p>Verification of Requestor's Identity:</p> <p><input type="checkbox"/> Photo ID</p> <p><input type="checkbox"/> Identifying Information</p> <p><input type="checkbox"/> Matching Signature</p> <p><input type="checkbox"/> Other:</p> <p>_____</p>	<p>If the request was submitted by a Personal Representative, the authority of the Personal Representative was verified by:</p> <p><input type="checkbox"/> Executed Will</p> <p><input type="checkbox"/> Documentation of Power of Attorney</p> <p><input type="checkbox"/> Signed Authorization by the Individual</p> <p><input type="checkbox"/> Other:</p> <p>_____</p>