HIPAA REQUEST FORM

If additional space is needed to detail request, please attach a sheet to this form.

1. RELEASE OF MEDICAL RECORDS

Name _____ **Date of Birth** _____
Social Security Number _____ **Phone** _____
Address if mailing records: _____

I hereby authorize Gastroenterology Specialties, PC and Lincoln Endoscopy Center, LLC to release information from my Medical record or Billing record as indicated to: _____
for the purpose of _____ (examples: treatment, personal file, insurance application). The date span to which the records are to be copied is:_____
Indicate if the records are to be faxed and what number. If picked up by who?

_____

This authorization expires in one year or on this date: _____
Specify **EXACT** records to be released and **CIRCLE** if they include the following:
Substance Abuse, Mental Health, HIV or **Genetic** records.

_____
_____
_____
_____

I am aware that Gastroenterology Specialties has 10 days with which to comply with my request.

2. REQUEST AMENDMENT TO HEALTH INFORMATION RETAINED IN DESIGNATED RECORD SETS.

Below is my explanation of how I believe the chart entry is incorrect or incomplete and my request to change the entry? After review of this request Gastroenterology Specialties will advise me of the outcome.

_____
_____
_____
_____

3. REQUEST FOR ACCOUNTING FOR DISCLOSURES OF HEALTH INFORMATION

I request an accounting for disclosures of my health information for the period _____
This will be mailed to me or faxed to _____

4. REGISTERING A PRIVACY COMPLAINT

I believe my privacy rights have been violated and a detailed description of the privacy issue involved in my complaint is provided below. The incident or problem occurred on _____ (month/day/year) if applicable. I can be reached during business hours at the stated telephone number. The Privacy Officer at Gastroenterology Specialties is Sharon Treat and can be reached at 402-465-4545. After review of this complaint Gastroenterology Specialties will advise me of the outcome.

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5. Right to Request Restrictions.

I have the right to request a restriction or limitation on the health information you use or disclose about me for treatment, payment, or health care operations. I request health or billing information requests be handled as follows. After review of this request Gastroenterology Specialties will advise me of the outcome.

_____

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6. Right to Request Confidential Communications.

I have a right to request the means by which you communicate with me for health or billing matters and will detail my requested below. After review of this request Gastroenterology Specialties will advise me of the outcome.

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Patient Name	**Patient Signature**	**Date**
	Guardian Signature	**Date**