RECIPIENT REQUEST TO ACCESS/OBTAIN COPY OF PROTECTED HEALTH INFORMATION

Recipient's Name: _____
Medicaid/Nevada Check Up ID #: _____

As provided by the Health Insurance Portability and Accountability Act, you have a right of access to inspect and obtain a copy of your Protected Health Information contained in a designated record set held by the Division of Health Care Financing and Policy (DHCFP).

(NOTE: DHCFP does not keep your complete Medical Records. Copies of your complete Medical Record should be requested from your health care provider.)

This right does not apply to:

1) Psychotherapy notes;
2) Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
3) Protected Health Information that is:
   a) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to you would be prohibited by law; or
   b) Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

Please indicate specifically the information to which you are requesting access: _____
_____
_____
_____
_____

DHCFP will respond to your request within 30 days from the date of your request or within 60 days if the requested information is not maintained or accessible to DHCFP on-site. Our response will either: (1) inform you of the acceptance of your request and provide you access and/or advise you when copies of the information you requested will be available; or (2) provide you a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed.

If the requested information is contained in more than one designated record set or at more than one location, and access is granted, DHCFP needs only to provide you with access to information contained in one of the designated record sets.

Please indicate the form or format in which you would like to receive your requested information:

_____

_____

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Please indicate the means by which you wish to inspect or obtain a copy of the requested information (fax, mail, on-site, etc.), and provide the necessary numbers or address:

_____

_____

_____

If DHCFP cannot provide the information in the form or format requested, it will be made available to you in a readable hard copy form or other form or format agreed to.

Do you agree to receive a summary of the requested information in lieu of access?

☐ Yes ☐ No

DHCFP may impose a fee of $5.00 for the first 5 pages and $.25/page thereafter to cover the cost of labor, copying, postage, and preparing a summary of the requested information. Do you agree to such fees imposed by DHCFP for providing a copy or summary of the requested information?

☐ Yes ☐ No

_____ _____

Signature of Recipient or Personal Representative | Today's Date

_____ _____

Printed Name of Recipient or Personal Representative | Relationship to Recipient or Authority to Act on Their Behalf

FOR DHCFP USE: Date request received by DHCFP: _____