

Texas Children's Hospital Patient Request for Access to Protected Health Information

*This form must be submitted by patients to request inspection and/or copies of their protected health information.
Please read the Instruction page (attached) before completing this form.*

I. Patient Name: _____ Birth Date: _____
Complete Address: _____
Home Phone: _____ Dates of Service: _____

II. I wish to (check one): Inspect the record Obtain copies of the record. (See fees on Instruction page.)

III. I want to inspect or obtain copies of the following reports (check):

Abstract - includes Face Sheet, Discharge Summary, History and Physical Exam, Operative and Pathology Reports, Consultation Reports, Radiology Reports and EEGs

Or:

- | | |
|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Clinic/Outpatient Record |
| <input type="checkbox"/> Consultation Reports | Which clinic or Dr? _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Billing Claim Forms |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Itemized Statement of Charges |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> All Information |

Or, for mental health records (May require physician/psychologist approval):

- | | |
|--|--|
| <input type="checkbox"/> Psychiatric/Mental Health Records | <input type="checkbox"/> LSC/CAP Records |
| <input type="checkbox"/> Neuropsychological Testing | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> All information | |

Please note that currently TCH can provide only paper copies for most reports.

IV. I request Texas Children's Hospital (TCH) to provide me with access to the protected health information about myself (or the patient) as described above. I understand:

- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- TCH reserves the right to verify my identity/guardianship.
- I will be charged for copies that I have requested.

Signature: _____ Date _____

Printed Name: _____ Relationship to Patient: _____

V. Mail copies to (address): _____

City, State, Zip: _____

Or, if you wish to pick up the copies, give phone number to call: _____

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Mail or deliver }
completed }
form to }

Release of Information
Medical Record Department
Texas Children's Hospital
6621 Fannin Street, MC 1-3225
Houston, TX 77030

For more information, contact Release of Information
Medical Record Dept., 832/824-1634, -1651, or -1670
or Patient Accounting 832/824-2300.

Instruction Sheet for Patient Request for Access to Protected Health Information

Patients have the right to access their protected health information. This means that you may inspect (view) or obtain copies of your information as maintained by Texas Children's Hospital (TCH) in your medical or billing records. If you wish to do this, you must fill out and submit to TCH the "Patient Request for Access to Protected Health Information" form. If the patient is a minor child, the legally authorized representative (e.g., parent) may request access to the child's record. TCH will review all requests for access and respond within 15 days of the date the request is received. Please note that in a few limited cases as described by law, TCH may deny the patient access.

*Please follow the instructions below when filling out the Request form.
Numbers I – V refer to sections I-V on the form.*

I. Who is the patient?

Fill in the identifying data for the patient (or yourself, if you are the patient) so that we can locate the proper record. Give the patient's name, birth date, address, phone and dates of service for the hospitalization, treatment, test, or visit. If you do not know the exact dates of service, give a close range of dates.

II. Do you want to inspect the information or obtain copies?

Please check whether you want to inspect (view) the information or get copies of the information, or both. If you want copies, you will be charged according to the number of copies you request. The fees are based on state regulations. If you want to inspect your record, you will be called at least 24 hours in advance to set up an appointment for the inspection during business hours, Mon. – Fri. (A Medical Records staff member will assist you during the inspection but is not authorized to give any clinical explanation.)

III. Which information from the record do you want to inspect or receive copies of?

From the list of reports given, place a check mark by the reports that you want to see or have copied. Do not just mark "All Information" without considering the cost of the copies. Many patients choose the abstract because it provides key documents. (See the fees for copies below.)

IV. Have you signed the form?

Please read the statements and sign to indicate your understanding. If you do not understand any of these statements you may call the TCH Release of Information Office for more information.

V. How will you get the copies? By mail or will you pick them up?

Please give your mailing address if the address is different from the patient's address. Or, give the phone number at which you can be reached to pick up the copies when ready. (This saves you the cost of mailing.)

Copy fees and timeframe: *You will be billed for the number of copies you request in accordance with state law (see Copy Fee Schedule below). Once payment is received, TCH will provide the copies requested within 15 days.*

Copy Fee Schedule:

Basic fee - Includes first 10 pages	\$35.30	
Next pages, 11-60	1.18 per page	For records stored on microfilm:
Next pages, 61-400	.59 per page	Basic fee - Includes first 10 pages
Next pages, 401 and up	.30 per page	Next pages, 11 and up
		1.18 per page

Plus any applicable postage fees.