Request for Beneficiary Access to Protected Health Information

Mississippi Division of Medicaid, Privacy Officer
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201
Toll-free: (800) 421-2408 | Phone: (601) 359-6050

Si necesita esta información en español, por favor llame 1-800-421-2408

Under the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct ("HIPAA") of 1996, you have the right to request the opportunity to inspect and obtain a copy of your **p**rotected **h**ealth **i**nformation ("**PHI**"). The Mississippi **D**ivision **o**f **M**edicaid ("**DOM**") will evaluate your request and either grant it or explain the reason why it will not be granted. Your right to access does *not* extend to:

1. Psychotherapy notes;
2. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
3. PHI that is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, if the denial of access under the Privacy Act would meet the requirements of that law;
4. PHI obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information;
5. Access to PHI that a licensed health care professional has determined, in the exercise of professional judgment, is reasonably likely to endanger the life or physical safety of you or another person;
6. PHI that makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
7. Requests for access made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to the personal representative is reasonably likely to cause substantial harm to you or another person.

I, ____,
(Applicant/Beneficiary's name – first, middle, last, maiden)
hereby request access to my Protected Health Information as indicated below:

Scope of access requested:

☐ All records
☐ Only records related to: ____
☐ Only records from (*enter dates*): ________________________ to ________________________

Type of access requested: *(continued on next page)*

☐ <u>Inspection.</u> Please let me know when I may come to inspect the records and the amount of any charges. I understand that a DOM staff member will be present and that I may not make any marks or alter the records in any way. I also understand that DOM may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of $10.00 per hour or any part of any hour, and the rate of $40.00 per hour or any part of any hour for professional staff time. I may be required to pay these costs before I inspect the records.

☐ <u>Copies.</u> I would like copies of all records requested. I understand that DOM may charge me a reasonable fee of up to $0.50 per page for copies (single sided), $1.25 per page for FAX copies, $7.00 per CD, or other possible costs for supplies or postage.

☐ I would like the information in the following form/format *(specify paper, electronic, CD, or etc.)*:
____

Choose one:
☐ I will pick up the requested copies on ____________________ *(mm/dd/yyyy)*.

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☐ Please send the requested copies to *(list mailing address, email, or fax number)*: _____________

Charges:

☐ I hereby agree to pay any reasonable costs or fees, as specified above. Please bill me *(once payment is received, the records will be released)*.

☐ Please contact me to let me know the total cost that I will incur.

Signature: By signing below, I hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

_______________________________________ _______________________________________

(Applicant/Beneficiary's Name) *(Date of birth – mm/dd/yyyy)*

_______________________________________ _______________________________________

(Social Security Number – xxx-xx-xxxx) *(Medicaid Identification Number)*

____

(Mailing address)

_______________________________________ _______________________________________

(Telephone number) *(E-mail address)*

_______________________________________ _______________________________________

*(Signature**)* *(Date signed – mm/dd/yyyy)*

*****If not signed by the Applicant/Beneficiary, please indicate your relationship to the Applicant/Beneficiary and attach any required documentation confirming your authority to act for the Applicant/Beneficiary***_______________________________

To get a copy of DOM's Notice of Privacy Practices, visit http://www.medicaid.ms.gov/Publications.aspx, contact a DOM Regional Office, or contact DOM at the above address or telephone number.

For official DOM use only:

Date request received:	Received by:
Request: ☐ Granted ☐ Denied Request: ☐ Mailed ☐ Given In Person ☐ Faxed Date (mm/dd/yyyy): If Inspection Requested Date of Inspection (mm/dd/yyyy): Fees Accessed:	Granted/denied by (Print Name): Title: Signature of DOM Representative: Date (mm/dd/yyyy):
Reconsideration: ☐ Granted ☐ Denied	Granted/denied by (Print Name): Title: Signature of DOM Representative: Date (mm/dd/yyyy):

Comment(s) and Action(s) Taken:

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