PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM
REQUEST FOR ACCESS TO ELECTRONIC HEALTH RECORD (EHR)
AFN: HIP-007 (12/2022)

Participant Name: **Participant ID #:**

I hereby request Public Safety/Corp Cancer Insurance Policy Program to:

Send me a copy of my electronic health record to:

Send a copy of my electronic health record to the following third parties:

a.
b.
c.
d.

And I understand that there is a nominal fee associated with the request which is:

Calculated fee for forwarding electronic health records:

This fee covers the cost of forwarding the aforementioned records. I also understand that I may be required to pay the fee in full before the request can be fulfilled.

I further understand that:

1) Public Safety/Corp Cancer Insurance Policy Program maintains electronic health records that contain protected health information about me as a participant, such as claims records, and records that are used, in whole or in part, to make decisions about me, my treatment, or payment for services
2) I have the right to inspect and obtain a copy of my above mentioned electronic health records maintained by Public Safety/Corp Cancer Insurance Policy Program.
3) My request must be made in writing using this form, which must be completed prior to Public Safety/Corp Cancer Insurance Policy Program providing me with the requested information.
4) If I request Public Safety/Corp Cancer Insurance Policy Program to forward my electronic health record, they have the right to charge me for forwarding the requested information to me or a third party that I designate.
5) I have the right to request an amendment to my protected health information mentioned above.
6) Within 30 days (60 days if information is not maintained or accessible on-site), I will receive a response from Public Safety/Corp Cancer Insurance Policy Program indicating whether my request for access has been accepted or denied, or a notification that they require an additional 30 days to consider my request. If they require an extension, they will explain the reason for the delay and the date by which they will make a decision. If they deny my request, they will inform me in writing of the reason for the denial, and instruct me on how I can go about disputing a denial or filing a complaint.

Participant: Your 'Typed' First and Last Name Constitutes Your Signature

Date *(MM DD YYYY format)*

Printed Name of Participant's Representative (*if applicable*)

Relationship to Participant (if applicable)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

Submit Button

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**** For Office Use Only ****

ID Verification Completed By:

Date Verification Completed:

(MM DD YYYY format)

Notes:

Request Accepted ☐ Denied ☐

Reason for Denial (*if applicable*)

- ☐ Access is likely to endanger the life or physical safety of the individual or another person
- ☐ Psychotherapy notes
- ☐ The information is compiled for use in a civil, criminal, or administrative action or proceeding
- ☐ Other (*full list of other reasons for possible denial at 45 CFR §164.524(a) (1)-(3)*):

Date Request Received **Received By**

Date Request Fulfilled **Fulfilled By**

Extension Requested **Yes** ☐ **No** ☐

Date Participant Notified in Writing of Extension

If Extension Requested, Give Reason