Health Horizons
609 Allegheny Avenue
Oakmont, PA 15139
412-828-0700

HIPAA PATIENT REQUESTS REGARDING HEALTHCARE RECORDS

*** New patients only need to complete the items with the * before them.**

I hereby request the following: (circle one)

- Restrict use and/or communication of my healthcare records
- Amend my healthcare records
- Provide a history of non-routine disclosures of my healthcare records
- Restrict confidential communication

* Restrict use and/or communication of my healthcare records in the following manner:

_____
_____

* List the family members or other persons whom we may give information regarding your care in our office. (Including picking up of medical records, appointment times, general medical information and diagnosis and notification in case of emergency)

_____
_____

*Print the address other than home that you want your records mailed to:

_____

*I want all correspondence from Health Horizons to be in a sealed envelope marked confidential: Yes or No _____

Amend my healthcare record as indicated:

_____
_____

*Amend confidential communication with me by Health Horizons as indicated below:

*Fax to this number only: _____
*Messages may be left at these phone #s only: _____
*Email correspondence sent only to this email address: _____
*Recall cards may be sent to me: Yes or No _____
*Phone calls may be made to my work number: Yes or No _____

I understand my requests, if granted, will remain in effect until such time I submit a request to change them in writing.

*_____ (Patient Signature)

*_____ (Date)

*_____ (Relationship to Patient)

_____ (Verification By)

For Office Use Only

_____

- This request has been approved: Yes or No _____
- This request has been denied for the following reasons:
  _____
- Signature of Compliance Officer: _____
- Date of Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been made aware of Health Horizons' Notice of Privacy Practices. I understand that I may request a copy of the Privacy Practices at any time. I also understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in my treatment.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

(Please Print Name)

_____ _____

(Signature) (Date)

_____

For Office Use Only

_____

We attempted to obtain acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

_____ _____

(Staff Signature) (Date)