Central Arkansas Ophthalmology
Comprehensive Eye Care & Surgery

HIPAA Privacy Rights Request Form
(Including Request to Release PHI)

Patient Name: _____ Date of Birth:_____

I have received the Notice of Privacy Practices on behalf of Central Arkansas Ophthalmology and understand my rights with respect to my Protected Health Information (PHI) and its use and disclosure by Central Arkansas Ophthalmology. According to the Notice of Privacy Practices provided, I am requesting in writing the exercise of my rights as follows:

Type of Request:

☐ Inspection/Copy (fees may apply) ☐ Amendment/Correction ☐ Restriction
☐ Accounting of Disclosures ☐ Alternative Communication ☐ Complaint
☐ Request to Release PHI – From:_____ To:_____

Please describe **in detail** the nature of the action requested. Attach additional documentation, if applicable, including information of where medical records should be sent including applicable address & phone number.

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_____ Date:_____ _____
Signature of patient or legal representative Printed name of patient or legal representative

Please fax information to (501) 664-5257 or mail to 5300 W. Markham, Little Rock, AR 72205. Please call (501) 664-5354 for questions.

Please initial by each applicable request.

_____**For Inspection/Copy or Request to Release PHI:** I understand that Central Arkansas Ophthalmology is authorized to charge reasonable cost-based fees for copying and postage or for the storage medium requested to send my records. For copies, I may be charged $.50 per page for the first 25 pages and $ .25 per subsequent page. If I request my records be sent electronically by a specified format, I may be charged for the storage medium requested such as CD-ROM. I may be charged for actual postage required to mail my records.

_____**For Amendment/Correction:** I understand that my request to amend/correct my PHI may be denied by Central Arkansas Ophthalmology if in the professional opinion of my physician, the PHI is accurate and complete. I understand if my request is denied, I have the right to have the denial reviewed by a licensed healthcare professional who is not directly involved in the denial of my request, and Central Arkansas Ophthalmology will comply with the outcome of the review.

_____**For Restriction:** I understand that if am restricting the use and disclosure of my PHI to my health plan for a particular service or test provided to me, I must pay for that service or test out-of-pocket at 100%. I also understand that the service or test will not be filed with my insurance company and therefore will not count toward my deductible or plan maximum.

_____**For Accounting of Disclosures**: I understand that I may request an accounting of all disclosures of my PHI for a specified time period not to exceed the previous 6 years and that Central Arkansas Ophthalmology has 30 days to comply with my request.

_____**For Alternative Communication:** I understand that I may request a reasonable method/location for confidential communication with Central Arkansas Ophthalmology.

_____**For Complaint:** I understand that I have the right to file a complaint if I feel that my privacy rights have been violated. I know that I will not be penalized in any way for submitting my complaint regarding the use and disclosure of my PHI.

For Office Use Only:
ActionTaken:_____Date_____
Privacy Officer Signature:_____Date:_____