TAB 39
Access Request Form

See attached

DEPAUL FAMILY AND COMMUNITY SERVICES
ACCESS REQUEST FORM

Patient's Name:	________________	________________	________________
	Last	First	Middle
Home Address:	________________________________		
	________________________________		
Home Phone:	________________		

I hereby request that DePaul Family and Community Services ("FCS") provide me with ☐ **an electronic copy** OR ☐ **a paper copy** of the "Requested Information" checked below:

☐ My medical records

☐ My billing records

[Please also check one of the three boxes below:]

☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period ________ through ___________.

☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by FCS.

☐ I would prefer to receive the Requested Information in the form of a summary prepared by FCS at a cost to me of $0.50 per page for copying costs and $25.00 per hour of clerical work necessary to complete the work.

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or other information limited or restricted by applicable law. If I am a parent or legal guardian requesting access to information about a minor 12 years old or older, I further understand that under certain circumstances I may not be provided access to records about mental health or developmental disability services.

I understand that FCS may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by FCS who did not participate in FCS's decision to deny my request.

I understand that FCS will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within 30 days of receiving this request.

Please provide the Requested Information to me in **[please check the appropriate**

boxes] ☐ electronic form (on a disc) **OR** ☐ paper form. I would prefer to: ☐ pick-up or view the Requested Information at a mutually agreeable time and place; **OR** ☐ have the Requested Information mailed to me at the following address:

____
____
____

I understand that FCS may charge me reasonable costs per page for the labor associated with copying the records that I am requesting (whether in paper or electronic form) and for the supplies to create the paper copy or electronic media (if I have requested that an electronic copy be provided on portable media), as well as the actual costs of postage if I request that the information be mailed to me. If I am granted access to the Requested Information, I **[please check the appropriate box]** ☐ would ☐ would not like FCS to provide me with an additional written explanation of such Requested Information at an additional cost to me of $0.50 per page for copying costs and $25.00 per hour of clerical work necessary to complete the work.

By: ____________________________ ___________, 20__
Signature of Patient (or Personal Representative) Date of Signature

INSTRUCTION: Please complete the following information if the patient's parent or other personal representative will sign this request form. The patient must be at least 12 years old to sign this request form.

____
Printed Name of Personal
Representative (*if applicabl*e)

____
Relationship of Personal Representative to Patient
(*if applicable*)

* * * * *

After you have completed this Access Request Form, please deliver it to the FCS Business Manager by mail to 2219 N. Kenmore Ave., Suite 300, Chicago, Illinois 60614, by fax to 773-325-7781 or by email to DePaulFCS@depaul.edu. If you have any questions about this Access Request Form, please contact the FCS Business Manager by phone at 773-325-7788 or at the addresses or phone numbers in the preceding sentence.

TAB 40
Denial of Access Form

See attached

DEPAUL FAMILY AND COMMUNITY SERVICES
DENIAL OF ACCESS FORM

Patient's Name:	____
	Last First Middle
Home Address:	____
	____
Home Phone:	________________
Date of Access Request:	________________

Your request to access or obtain a copy of your protected health information from DePaul Family and Community Services ("FCS") has been denied for the following reason: ____
____
____.

In accordance with applicable federal and state law and FCS privacy policies, you **[please check the appropriate box]** ☐ do ☐ do not have the right to have this denial reviewed by a licensed health care practitioner who did not participate in the decision to deny your request. If this denial is reviewable in accordance with the above and you desire to have the decision reviewed, please check the box below and return this form to the FCS Business Manager in person or by mail to 2219 N. Kenmore Ave., Suite 300, Chicago, Illinois 60614, by fax to 773-325-781 or by email to DePaulFCS@depaul.edu.

If you want to make a complaint regarding this denial, please contact the FCS Business Manager by mail at the above addresses or phone number. Your written complaint should include your name and the specific details of your complaint.

* * * * *

☐ I hereby request a review of FCS's denial of my request to access or obtain a copy of my personal health information by a licensed health care practitioner selected by FCS who did not participate in the decision to deny my request.

By: ______________________________ __________ __, 20__
Signature of Patient (or Personal Representative) Date of Signature

INSTRUCTION: Please complete the following information if the patient's parent or other personal representative will sign this request form. The patient must be at least 12 years old to sign this request form.

Printed Name of Personal Representative

____

____
Relationship of Personal Representative to Patient
(*if applicable*)

* * * * *

After you have completed this form to request a review of an access denial, please deliver it to the FCS Business Manager by mail to 2219 N. Kenmore Ave., Suite 300, Chicago, Illinois 60614, by fax to 773-325-7781 or by email to DePaulFCS@depaul.edu. If you have any questions regarding this denial, please contact the FCS Business Manager by phone at 773-325-7788 or the addresses and numbers in the preceding sentence.