Request to Inspect Health Information

This form is used for an Individual to request access to their protected health information (PHI). Individuals generally have the right to inspect and obtain a copy of PHI about the Individual in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set. A "designated record set" is a group of records maintained by or for HealthTrust Inc. that is 1) the medical records and billing records about individuals maintained by or for a covered health care provider; 2) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3) used, in whole or in part, by or for HealthTrust Inc. to make decisions about Individuals. Record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for HealthTrust Inc. (45 CFR § 164.524).

I request to review health information held about me in HealthTrust's "designated record set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (please check all that apply).

☐ I request an opportunity to review the information at HealthTrust Inc. offices.

☐ I request a copy of the information be provided in the following format (please check one).

☐ Paper ☐ Electronic

By signing this form,

- I understand that HealthTrust Inc. has 30 days to respond to this request, and that if someone else holds the information or it is off-site, the response time is 60 days.
- I agree that HealthTrust Inc. may provide a summary of the health information instead of allowing me to review the information.
- I understand that this request does not apply to certain health information, including 1) information that is not held in the designated record set; 2) psychotherapy notes; 3) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and 4) other information not subject to the right to access information under HIPAA.
- I agree to pay any fees for copying or summarizing my health information. Fees will be reasonable and cost-based, and include only the cost of copying, postage, and preparation of a summary (if I agree to a summary).
- I understand that, if my request is denied, I may file a complaint regarding this decision with HealthTrust Inc. or the U.S. Department of Health and Human Services. If filing a complaint with HealthTrust Inc., it must be in writing to: Privacy Officer, PO Box 617, 25 Triangle Park Drive, Concord, NH 03301 or privacyofficer@healthtrustnh.org.

Your Name (printed):	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g. Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER Reference: HIPAA Individual Rights Policy.	
Name of HealthTrust Workforce Member Receiving Form:	Date: