



HIPAA Information Request Form

Per the Health Insurance Portability and Accountability Act (HIPAA), you have the right to make requests on you or your child's Personal Health Information (PHI) in ChildNet's records. ChildNet will evaluate all requests and will either grant or explain the reason why a request was declined. **Please complete and notarize this form and submit it to ChildNet's HIPAA Client Resource Coordinator.** Notaries are available at ChildNet.

Today's Date: / /	First Name:	Last Name:
Street Address:		
City:	State:	Zip Code:
Home Phone: () -	Work Phone: () -	
Fax (if available): () -	Email Address (if available):	

Are you completing this request form on behalf of someone else? (check one)

Yes No

If Yes, what is the person's name and your relationship to that person?

First Name: | Last Name: | Your Relationship:

Type of Request: (check all that apply)

- View my (or my child's) PHI as available in ChildNet's records/case file
- Get copies of my (or my child's) PHI as available in ChildNet's records/case file
- Update my (or my child's) PHI
- Correct/Delete existing PHI
- Place limits on uses and disclosures of my (or my child's) PHI
- Receive list of disclosures of PHI made by ChildNet
- Change how ChildNet sends PHI to you (i.e. select alternative address)

Please describe in detail the nature of your request:

If appropriate, attach a copy of all supporting documentation to this request form.

Signature: _____ Date: ____/____/____

NOTARY SEAL REQUIRED

CN 009.034
August 2007
Human Resources

Send to:
ChildNet
HIPAA Client Resource Coordinator
313 N. State Road 7
Plantation, FL 33317

ATTACHMENT 5



HIPAA Information Request Form

For Internal Use Only:

Date Request Received: / /	Date Receipt of Request Form Acknowledged: / /
Has the request been approved: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If <u>Yes</u> , describe how the request will be met:	
If <u>No</u> , describe why the request has been declined:	
Additional comments by HIPAA Client Resource Coordinator <i>(if applicable)</i> :	
Date Request Approval/Denial Submitted: / /	

HIPAA Client Resource Coordinator

Date