THE UNIVERSITY OF TEXAS SYSTEM ADMINISTRATION
HIPAA PRIVACY MANUAL

Request for Access to Protected Health Information

Name: ____________________________ Daytime Phone # ________________________

Address: ____

DOB:____________ Benefits ID #* ______________ Email address:________________
(**If you are requesting this information as a Personal Representative, you *must* provide your contact phone number and street or e-mail address:**
____
____)

I request access to medical information maintained by or for System about me as a member of (check all that apply):

- ☐ UT Health SELECT,
- ☐ UT Dental SELECT.
- ☐ UT Flex
- ☐ Other (explain)________________________

____

I request access to the following medical information (please specify the exact information to be disclosed, including, if applicable, dates of service):

- ☐ My complete medical record (Note: May include HIV, mental health or drug and alcohol treatment or other sensitive records)
- ☐ Other (list types of records requested, may include dates of service if desired):

____
____
____
____
____.

I request access to the medical information in the following form:

- ☐ On-site access to the records
- ☐ Copies delivered to me by mail to the following address:

____
____
____
____

☐Copies delivered to someone else by mail to the following address:

____
____
____
____

- ☐ Copies faxed to me at the following number: ______________________________
- ☐ Other: ____

Please note; if you request records to be sent via email, we cannot guarantee that they will be secure or confidential during transit or in the email account to which they are sent.

* You can look up your UT System Benefits ID number at:
https://utdirect.utexas.edu/nlogon/sgwww/SGPNIBID.WBX

In addition, we assume no responsibility for the security or confidentiality of records provided to a third party at your request.

I understand that System may charge a fee for the costs of copying, mailing, or other supplies associated with this request.

I further understand that System may, under applicable law, deny my request to access my medical records in certain limited circumstances. In some cases, if I am denied access to my medical information, I may request that the denial be reviewed, in which case a licensed health care professional chosen by System will review my request and the denial. The person conducting the review will not be the person who initially denied the request. System will comply with the outcome of the review.

Signature: ___________________________________ Date: ________________________

If you sign this request as the Legal Representative of the individual, you *must* provide adequate documentation of your authority to serve as the person's representative *and* sign below:

Printed name of legal representative: ____

Representative's authority to act for individual: ____

For System Use Only

Person processing request for access: ________________________

Date request received: ___________________

Any requested PHI maintained off-site? ☐ Yes Location: _____________________________________
☐ No

Deadline to grant/deny requested access: ___________________
Was there an extension of the deadline?
☐ No
☐ Yes: Reason: ____
Date written notification given: __________________________
New deadline to grant/deny access: ______________________

Access: ☐ Granted ☐ Denied Date individual notified: ___________________
If granted:
Date access granted: ___________________
How access provided: ____
Fee charged: ____
If denied, reason____
____
If denied for reviewable grounds:
Did individual request review of denial?
☐ No
☐ Yes