Contact Information:
Privacy Officer, Crawfordsville Health and Wellness Center
1720 Lafayette Road STE A, Crawfordsville, IN 47933
Telephone: 765-626-4689

Patient Right Requested: (check the patient right (s) you want to exercise)

☐ Access Medical Records ☐ Confidential Communication
☐ Restriction Request ☐ Accounting of Disclosures
☐ Amendment Request

Please provide us with the following information:

Patient's Name:		Telephone Number:
Address:		
City:	State:	Zip Code:
Social Security Number:	Date of Birth:	

Accessing Your Medical Record

You have the right to inspect and obtain a copy of your protected health information in the medical record that we maintain. To exercise your right of access, please complete the following**:**

Type of Access Requested	**Information to be Copied or Inspected**
☐ **Copies of the record** ☐ **Inspection of the record**	☐ **Nursing Notes** ☐ **Labs** ☐ **MD Progress Notes** ☐ **Entire Record** **Other:**_____ _____

Confidential Communication

You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location.

Describe the protected health information you want to make subject to confidential communication:

☐ **lab results** ☐ **treatment information** ☐ **billing**

☐**Other: (please explain):**
_____

How do you wish for this department to communicate with you?

☐ **Phone number: _____** ☐ **E-mail Address: _____**

☐ **Fax number: _____** ☐ **Other: (please explain): _____**

Restriction Request

You have the right to request that we restrict the use or disclosure of your protected health information, including for treatment, payment or our health care operations. We are not legally obligated to honor your request. To exercise your right to request restriction on the use or disclosure of your protected health information, please complete the following:

Specify the protected health information, the use or disclosure of which you want to restrict:

☐ **lab results** ☐ **treatment information** ☐ **billing**

☐ **Other: (please explain):** _____

State the restrictions you want to apply to that protected information:_____

_____

Accounting of Disclosures

You have the right to an accounting of the disclosures Rush or its business associates have made of your protected health information. You are entitled to one free disclosure accounting every 12 months. To receive an accounting of disclosures please provide the dates of disclosures you want us to account for:

From: _____/_____/_____ To:_____/_____/_____

Amendment Request

You have the right to request that we change or amend your protected health information in the medical record that we maintain. We may deny your request in certain circumstances**.**

To exercise your right to request amendment, please complete the following:

Specify the records you wish to amend and the amendments you wish to make:

☐ **lab results** ☐ **treatment information** ☐ **billing**

☐ **Other: (please explain):**
_____

State the reasons for the amendment request:
_____

_____

PATIENT'S SIGNATURE: _____ Date: _____

If this request is by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Personal Representative's Signature:_____

Relationship to Patient:_____