FORM 09aHIP

Request to Access, Inspect and Copy Protected Health Information for Minors

UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY
AND UNIVERSITY OF LOUISVILLE CARE PARTNERS

REQUEST TO ACCESS, INSPECT & COPY PROTECTED HEALTH INFORMATION OF A MINOR

As stated in our Notice of Privacy Practices, if you are the parent or legal guardian of a minor, you may request access to and obtain a copy of the minor's protected health information created and maintained by University of Louisville School of Dentistry and/or University of Louisville Care Partners.

The Health Insurance Portability and Accountability Act ("HIPAA") defines the situations in which we may deny access to your protected health information. If we are unable to grant your Request, we will send you an explanation in writing, along with information regarding your right to review our denial of your Request.

We will respond to your Request to Access within 30 days from the time we receive your completed request. In the event that your form is incomplete, we will contact you to ask you to re-submit the form. You may be charged a fee for copies of your health information.

* * * *

By signing below, I request access to inspect and obtain a copy of the protected health information of the minor listed below which is maintained by University of Louisville School of Dentistry and/or University of Louisville Care Partners. I understand that this Request does not provide me the right to access, inspect or copy any protected health information that is prohibited from disclosure by HIPAA or other Federal or State law.

* * * *

Describe the medical or health information you wish to access, inspect or obtain a copy of:

_____

I would like to receive my information by the following method (please select one):

☐ Mailed (please provide address):_____

☐ E-Mail (please provide address):_____

☐ I will pick up (please provide a phone number): _____

_____ _____

Patient Signature **Printed Name**

_____ _____

Date of Birth **Telephone**

_____

Print Name of Patient's Personal Representative (if signing for Patient)

_____ _____

Date **Date Request Received** (to be completed by ULSD AND/OR ULCP)