

Client Request to Access Protected Health Information

You have the right to inspect, or to obtain a copy of, your protected health information ("PHI") maintained in the designated record set by Sedgwick County. This request should include name, address, description of records to be copied, and phone number if necessary for contact or follow-up. Information should include personal identification of the client whose PHI is being requested. Personal identifiers include Social Security number and date of birth. A written request must be completed prior to Sedgwick County providing you with the requested information. Multiple departments may have your records. Please submit a separate request to each department from which you are requesting PHI.

Sedgwick County will make every reasonable effort to provide the PHI requested in the format requested by you if it is readily producible in such format. If it is not readily producible in such a format, Sedgwick County will make every reasonable effort to provide access to the PHI in a legible hard copy format, or in such other form, as agreed upon by you and Sedgwick County. Sedgwick County may charge fees to provide copies of records and will apply guidelines and fee schedules established for compliance with the Kansas Open Records Act to this purpose.

Sedgwick County may provide you with a summary of the PHI requested, in lieu of providing access to the PHI, or may provide an explanation of the PHI to which access has been provided, if you agree in advance to accept:

1. The summary or explanation **and**
2. The reasonable fees imposed.

I hereby request Sedgwick County copy the following records for _____ and mail to requestor.
Please complete the information below:

Client Information (Social Security Number optional for Health Department)

Client Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____

ZIP Code: _____ Phone: _____ E-mail: _____

Authorized Representative Information (If completing form on behalf of another)

Representative Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

ZIP Code: _____ Phone: _____ E-mail: _____

Select the Department(s) you are requesting records from:

EMS Health Department Department of Aging CDDO COMCARE

Service Start Date: _____ Service End Date: _____

Describe Records: _____

Date Printed Name of Client or Representative Signature of Client or Representative

For Office Use Only: The Fee for copying protected health information or providing a summary is _____.

Action Line: _____

Department Privacy Officer

Date