Urology Associates of Columbus, PC

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# HIPAA PRIVACY PATIENT RIGHTS REQUEST FORM

**Pertains to: A. Amendment, B: Restrictions,**
**C: Accounting of Disclosures, D: Confidential Communications**
This form is used when individuals wish to request their rights under HIPAA.

**PATIENT NAME** _____ **DATE OF BIRTH**_____

**MEDICAL RECORD NUMBER** _____ **ACCOUNT NUMBER** _____

**PATIENT ADDRESS** _____

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**A. Amendment Request**: I hereby request that Urology Associates of Colubmus, PC change or amend my protected health information in (*Check all that apply)*:

- ☐ Medical records *(Treatment Information and/or lab results)*
- ☐ Billing records
- ☐ Other (*Please describe*)

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

Date(s) of information to be amended (e.g., date of office visit, treatment, or other services):

FROM (Date) / / TO (Date) / /

FROM (Date) / / TO (Date) / /

State the reason(s) for the amendment request:

How is the entry incorrect, incomplete, or outdated?

What should the entry say to be more accurate or complete?

**A. Amendment Request (Continued)**

1538 13th Avenue, Bld. A Columbus, GA 31901
Office: (706) 323-4000 Fax: (706) 323-4848
www.urology2.com

**FORM Gs**

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? ☐ Yes ☐ No
If yes, please specify the name(s) and address(s) of the organization(s) or individual(s).

**B. Restriction Request**: I hereby request that Urology Associates of Columbus restrict the use or disclosure of my *(Check all that apply):*

- ☐ Medical records *(including those for treatment, payment or healthcare operations)*
- ☐ Billing records
- ☐ Other *(Please describe)*

What protected health information (item, service or visit) would you like restricted from disclosure?

Date(s) of information to be restricted (e.g., date of office visit, treatment, or other services):

FROM (Date) / / TO (Date) / /

FROM (Date) / / TO (Date) / /

What is your reason for making the request?

From whom is the information to be restricted?

What is the duration of the restriction?

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**C. Accounting of Disclosures Request:** I hereby request a HIPAA-compliant Accounting of Disclosures.

FROM (Date) / / TO (Date) / /

What is your reason for making the request?

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You are entitled to one free disclosure accounting in a 12-month period. For each additional disclosure accounting request during the same 12-month period, Urology Associates of Columbus will charge you $25.00.

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**FORM Gs**

**D. Request for Confidential Communications**: I hereby request a HIPAA-compliant alternate means or that confidential communications be sent to an alternative location.

Please list the address or method by which you would like Urology Associates of Columbus to communicate about all or part of your protected health information. *(i.e., postal mail, email, telephone)*

_____

Postal Mailing Address

_____ _____

Telephone Email

Besides you, are there any parties that you will specifically allow to receive communications about all or part of your protected health information? *(Provide Name, Relationship to patient)*

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I understand that Urology Associates of Columbus may approve or not approve some of these requests as permitted under federal law, and that I will be informed by Urology Associates of Columbus concerning the granting or denying of this request. Please consult this Organization's 'Notice of Privacy Practices', which is available to you upon request, for more details about your rights under HIPAA. We will process your request(s) as soon as possible; but in some cases, we may have 60 days to respond, plus an extension period of 30 additional days.

Patient or
Personal Representative Signature: _____ Date: _____

Printed Name of Patient
or Personal Representative: _____

**FORM Gs**