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 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)**

	Client	**Personal Representative of Client** (If different)
Name:		
Address:		
City, State, Zip Code:		
Date of Birth:		
Social Security Number:		
Phone Number*:		

** If necessary to contact or follow up.*

Please check the appropriate box, add dates, and describe records to be copied.

☐ EMS ☐ Division of Health ☐ Department on Aging ☐ COMCARE ☐ CDDO

Start Date: _____ End Date: _____

Describe Records:

Signature of Client	Signature of Personal Representative of Client
Date	Personal Representative's Authority to Act for Client (Such as: parent, guardian, power of attorney)

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

_____ _____
Privacy Officer Signature *Date*

Original to client's file.