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Kenyon Chiropractic PC
2003 West Owen K. Garriott Road Enid, Ok 73703
Tel 580-2372289 Fax 580-237-3751
dockenyon33@yahoo.com
www.kenyonchiro.com

Request for Accounting of Disclosure

This form is used to request an accounting of disclosures of protected health information that our practice has made during a specified time period.

Patient Name: _____Date of Birth: _____

Address: _____

Specified Time Frame for Accounting (Please note, the maximum timeframe that can be requested is six year prior to the date of request):

From ____ /____ /_____ to ___/ ____/ _____

Please specify if you wish to limit our accounting to:

- ❑ Certain types of disclosure
- ❑ Disclosure to a specific entity*

Please provide details of the scope of disclosures below:

_____

_____

_____

_____

Fees: First Request in a 12-month period is free.
Subsequent requests: $ _____

I understand that there may be a fee for this accounting and wish to proceed. I also understand that the accounting will be provided within 60 days unless notified of an extension of up to 30 days, if needed.

Patient Signature: _____ Date: _____

Personal Representative:

Name: _____ Relationship to Patient: _____

Driver's License Number: _____ State: _____

* Our practice is not required to keep disclosures related to Treatment, Payment and Operations (TPO). Including disclosures to the following: incidental disclosures; pursuant to HIPAA compliant authorization, individuals involved in the

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patient's care, for national security or intelligence, to correctional institutions or law enforcement, in compliant limited data set disclosures prior to April 14, 2003.

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Complaint Form

Name of Complainant: _____

Address: _____

Phone: _____Email: _____

Description of Complaint:

_____
_____
_____
_____
_____
_____

Signature of Complainant: _____ Date: _____

What would you like to happen?

- ❑ I want someone to contact me by
  - Email
  - Phone
- ❑ I do not want to be contacted.
- ❑ Other:_____
  _____

OFFICE USE ONLY

Date Reviewed: _____ Reviewer: _____

Details and Findings:

_____
_____
_____

Follow up Completed by:

- ❑ Phone
- ❑ Mail
- ❑ Email

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Request to Terminate & Update PHI Use & Disclosure Authorization

I _____ hereby consent to **terminate** authorized use and disclosure of protected health information of my individually identifiable health information to the following individuals listed below:

1. Name _____ Relationship to Patient_____

2. Name _____ Relationship to Patient_____

I acknowledge that I will receive a response within [10] days from the date of this request. In the meantime, my PHI will continue to be authorized to the individuals listed on my initial PHI Use and Disclosure Authorization.

Signature _____ Date _____

I hereby request authorization for Kenyon Chiropractic to disclose my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient_____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

This authorization is effective through (check one):

- ❑ ____ /____ /____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Kenyon Chiropractic in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Kenyon Chiropractic until the termination request is received in writing and response is sent.

Authorization to Disclose: _____ Date: _____

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Request to TERMINATE Restrictions to Health Plan

I consent to terminate additional restrictions on the use and disclosure of protected health information to the health plan _____ for purposes of payment or health care operations relating to the following items or services:

- ❑ Chiropractic spinal manipulation
- ❑ Physical Therapy/ Rehabilitation
- ❑ DME Supplies
- ❑ Other:

_____
_____

_____
Name of Patient (Print)

_____ _____
Signature of Patient Date

Office Use Only

We hereby accept this request.

_____
Practice Representative (type/print)

_____
Practice Representative Signature

_____
Date

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Request for Alternative Communications

Patient Name: _____

Date of Birth: _____ Chart ID: _____

Address: _____

Request Date: _____

Please check the alternative means of contacting you and provide the necessary information below:

- ❑ Email: _____
- ❑ Cell Phone: _____
- ❑ Home Phone: _____
- ❑ Work Phone: _____

Please specify your alternative method of handling payments:

- ❑ Send statements and other medical documentation to the address listed above.
- ❑ Send statements and other medical documentation to the alternate address listed below:

_____
_____

Signature of Patient: _____ Date: _____

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Request to Restrict Disclosure to Health Plan

I am requesting that Kenyon Chiropractic withhold submitting health information to the health plan _____ for purposes of payment or health care operations relating to the following items or services:

- ❑ Chiropractic spinal manipulation
- ❑ Physical Therapy/ Rehabilitation
- ❑ DME Supplies
- ❑ Other:

  _____

  _____

In return, I have paid in full out of pocket for the items and services itemized above. This request is effective through (check one):

- ❑ ____ /____ /____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

_____
Name of Patient (Print)

_____ _____
Signature of Patient Date

Office Use Only

We hereby accept this request.

_____
Practice Representative (type/print)

_____
Practice Representative Signature

_____
Date

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Request to Inspect or Copy Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street City, State, Zip

Requested patient information

- ❑ **Treatment Notes**
- ❑ **Radiology Reports**
- ❑ **Intake Forms**
- ❑ **Patient Update Forms & Outcome Assessments**
- ❑ **Other _____**

Approximate dates of records you wish to review: From _____/_____/_____ to _____/_____/_____

Which do you prefer?

- ❑ I wish to inspect the requested records
- ❑ I wish to obtain a copy of the requested records
- ❑ I wish to inspect and copy the requested records

Fees: [insert fee information based on local state and federal regulations]
We will review your request to determine if the information can be made available to you. In some cases, we may be legally prohibited from disclosing certain information. For further details please refer to our *Notice of Privacy Practices*.

We will complete our review of your request within the next [20] days and contact you either by phone or writing to arrange for you to inspect or pick up a copy of your records. You will be informed of the total administrative fee (if applicable) upon approval of your request. If we are unable to accommodate or deny your request, we will notify you in writing.

Patient Signature: _____ Date: _____

Personal Representative of Patient (if applicable)

Name of personal representative: _____

Relationship to patient: _____ Driver's License Number _____State _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of personal representative: _____ Date: _____

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Request to Amend Patient Records

Please use this form to request the treating physician to amend or make corrections to your medical record. If mailing this form, address the letter to the Privacy Officer listed at the bottom of form.

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street City, State, Zip

Personal Representative of the Patient

Name: _____

Relationship to patient: _____ Driver's License Number _____ State _____

I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____

Date: _____

I request that the following medical record information be amended (attach a separate document if needed):

_____
_____
_____

Reason for the requested change:

_____
_____
_____

I understand that you will review my request to amend records and provide a written determination within 60 days. I also understand that Federal Regulations may not allow information to be amended under certain circumstances specified by HIPPA Privacy Rules 45 CFR 164.526. If the request is denied, I understand that I may submit a written statement explaining my disagreement with the decision, which statement will be included in my medical records, along with any response from the practice.

If the amendment is approved, in whole or in part, I understand the practice will make the appropriate amendment to my records and also is required to make reasonable efforts to inform and provide the amendment within a reasonable time to other entities or practices who received the PHI.

_____ _____
Patient Signature Date

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Drew Hartling
Privacy Officer

Kenyon Chiropractic 580-237-2289
2/12/18

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RESPONSE to Accounting of Disclosure Request

Patient Name: _____

Date of Birth: _____ Chart ID: _____

Address: _____

Request Date: _____

Dear [Patient]

In response to your request for accounting of disclosures of PHI during the timeframe of _____/_____/_____ to _____/ _____/_____ , the following list includes all disclosures we are required to reveal to you in accordance with the HIPAA Privacy Rule.

Date of Disclosure	Name of Entity	Description of PHI	Purpose of Disclosure

Should you have additional questions, feel free to contact me.

Sincerely,

Drew Hartling
Privacy Officer

Kenyon Chiropractic 580-237-2289
2/12/18

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RESPONSE to Request to Amend Patient Records

Patient Name: _____ Patient Chart/ID # _____

Date of Birth: _____ Date Of Amendment Request: _____

Dear [Patient]

On [date], you requested our practice to amend information contained in your medical record. Your request has been:

- ❑ Granted
- ❑ Denied
- ❑ Partially Granted

If granted, the following amendment has been made to your records (see attached document if information is not listed below).

_____

_____

_____

If denied, our practice denies your request for the following reasons:

- ❑ Our treating physicians/practice did not create the information.
- ❑ The requested information is not part of the designated record set as maintained by our practice.
- ❑ The information is accurate and complete.

If you disagree, you have a right to submit a written statement to the Privacy Officer in our clinic. You also have a right to submit a complaint to the US Department of Health and Human Services at www.hhs.gov/ocr within 180 days of any alleged violation. You must describe in your complaint any acts or omissions that you believe are in violation of the HIPAA Privacy Rule. Should you have questions regarding this amendment request, please contact me at [580-237-2289] or by mail at: 2003 West Garriott Road Enid, OK 73703

Sincerely,

Drew Hartling

Privacy Officer

Kenyon Chiropractic 580-237-2289
2/12/18

Signature: _____Date: _____

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RESPONSE to Request to Inspect or Copy Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street City, State, Zip

Access Request Date: _____

Dear [patient]:

In response to your request to inspect and/or copy your medical records, please see our response below:

- ❑ Granted

Please contact our Privacy Officer to arrange a convenient time for you to inspect your records (if applicable) and/or pick up a copy of your requested records. You may also request that we send this information to you via US Postal Service; clinic may charge reasonable fee.

- ❑ Denied- Our practice denies your request for the following reason:
  _____
- ❑ Partially granted- Our practice partially granted your request for the following reason:
  _____

Total Fee $_____.00

You may request a review of this decision by submitting a request to our practice's Privacy Officer.

Sincerely,

Drew Hartling
Privacy Officer

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2/12/18

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RESPONSE to Request Termination of Use and Disclosure of PHI

Patient Name: _____ Date of Birth _____

Patient Address: _____
Street City, State, Zip

Date of Patient Request: _____

We reviewed your request for restrictions on the use and disclosure of PHI on _____ / _____ / _____

- ❑ Your request has been accepted.

We will make the necessary assurances to accommodate your request. If you requested an update to the list of authorized individuals on your termination form, these have been updated as of the date of this response.

- ❑ We regret to inform you that your request has been denied for the following reasons:

_____
_____
_____

If you do not agree with our denial you may submit a complaint to the Secretary of Health and Human Services and/or a complaint to our clinic at the following address:

Attention: Drew Hartling

2003 West Owen Garriott Road
Enid, Oklahoma 73703

Sincerely,

Drew Hartling
Privacy Officer

Kenyon Chiropractic 580-237-2289
22/12/18

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