CULINARY Health Center

Instructions for Completing the Individual Rights Request Form

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rule gives patients rights ("Individual Rights") over their protected health information ("PHI"). To exercise your Individual Rights at the Culinary Health Center* ("CHC"), please complete and send this form:

- ❑ **In person:** Hand in at the CHC
- ❑ **By mail to:** Culinary Health Center
  Attn: HIPAA Privacy Team
  650 N. Nellis Blvd.
  Las Vegas, NV 89110
- ❑ **By fax to:** 630-236-5286
- ❑ **By email to:** HIPAA@culinaryhc.com

  Please note: If you choose to email personal information to the CHC, we can't ensure it will remain private or secure until it's received.

For help: Call **702-790-8000** and ask for the Patient Experience Team or the HIPAA Privacy Team.

Your Individual Rights and what section of this form you need to complete.	
Authorization for Release of Protected Health Information ("PHI") Complete separate form	Patients have the right to request the CHC disclose their PHI directly to another person or entity designated by the patient. The patient's request to disclose the PHI to another person or entity must be in writing, signed by the individual, and clearly identify the designated person and where to send the PHI. Patients also have a right to request to view or get a copy, or both, of the PHI kept about them in their Designated Record Set which may include medical and billing records or other records used to make decisions about the patient. To make either of the above requests, please use the Authorization for Release of Protected Health Information Form, which is separate from this form.
Request to Amend or Change PHI Complete Section C	Patients have the right to request a change (amendment) to their PHI if they believe that it's incorrect or incomplete. The CHC will review the request and either correct the record and inform the requestor or notify the requestor the request has been denied (usually within 60 days). If the record is corrected, with the Patient's consent, the CHC will make reasonable efforts to provide the corrected information to its business associates and others who may have relied, or could reasonably rely, on such information to the harm of the Patient. If the request is denied, the requestor may also file a statement of disagreement.
Request to Restrict or Limit the CHC's Use or Disclosure of PHI (or to terminate a prior restriction or limitation) Complete Section D	Patients have the right to request that the CHC restrict its use or disclosure of their PHI for treatment, payment or healthcare operations or to family members or others who are involved in their healthcare or payment for healthcare. Because of the administrative difficulties involved in applying these types of requests for restrictions, except in limited circumstances, CHC does not generally agree to such restrictions. CHC will make every effort to inform Patients of the decision within 30 days.

Request to Receive Communications of PHI by Alternative Means or at Alternative Locations (or to modify or terminate a prior confidential communication request) Complete Section E	Patients have the right to request to get communications of their PHI by an alternative means (such as by email instead of mail) or at an alternative address (for example, at a P.O. Box instead of a home address). The CHC will make every effort to fulfill reasonable requests and inform Patients of the decision within 30 days.
Request to Receive an Accounting of PHI Disclosures Complete Section F	Patients have the right to request to receive an accounting of PHI disclosures maintained in their Designated Record Set during the prior 6 years. The accounting will be provided as quickly as possible (generally within 60 days) at no charge for the first request (more requests may require a small fee). **The accounting will not include disclosures of PHI made:** • More than 6 years ago • That are necessary, for treatment, payment, and healthcare operations purposes • To the Patient, the Patient's personal representative, or pursuant to an authorization • To correctional institutions or temporarily suspended by law enforcement officials • For national security or intelligence purposes, as part of a Limited Data Set or pursuant to a federal law that does not require CHC to provide an accounting
Request to File a Privacy Complaint Complete Section G	Patients have a right to file a complaint if they believe that the CHC has violated their privacy rights or if they have concerns about CHC's privacy practices. Patients may also file a privacy complaint with the Department of Health and Human Services at **www.HHS.gov**. The CHC will investigate the complaint and communicate the outcome to the Patient (usually within 30 days).

CULINARY Health Center

Individual Rights Request Form

You are required to complete the following sections:

- ❑ Sections A and B
- ❑ Any section that corresponds to the Individual Right you are requesting (Section D, E, F, or G) and
- ❑ Section H

Section A: Patient Information (this section is required).

Patient's name:

Street address:

City, state and zip:

Phone number: ( )

Date of birth: _____/_____/_____

Last four digits of Social Security number:

Relationship to Participant:

Section B: Participant Information (this section is required if different from Patient)

Participant's name:

Date of birth: _____/_____/_____

Last four digits of Social Security number:

Section C: Request for Amendment of PHI

Describe the PHI requested to be changed, how it should be changed, and the reason for the change:

❑ **If this request for amendment of PHI is approved, please notify the following individuals/organizations:**

Name: _____ Contact Info:_____

Name: _____ Contact Info:_____

Section D: Request for Restriction (or Termination of Restriction) of PHI

Do not release Patient's PHI related to (check all that apply):

❑ Any medical diagnosis or treatment

❑ A specific diagnosis – state diagnosis:

❑ Treatment between these dates: _____/_____/_____ and _____/_____/_____

❑ Other – explain:

Do not release Patient's PHI described above to:

❑ Anyone other than the Patient

❑ A specific person: Person's name: _____Relationship to patient:_____

❑ **Provide the reason for this restriction request:**

❑ **Check this box to request termination of a prior restriction on the CHC's use/disclosure of PHI.**

Section E: Request for Confidential Communications (or Termination of a Confidential Communication Request)

❑ **Provide communications of my PHI at the following alternative means or location:**

Alternative phone number: ( )

Alternative email address:

Alternative fax number: ( )

Alternative address:

❑ **I request termination of a prior confidential comm. request and am providing a new means or location.**

Section F: Request for an Accounting of Disclosures

❑ **Provide an Accounting of Disclosures for:** From (date): ____/____/_____ Through (date): ____/____/_____

Provide the Accounting of Disclosures in the following way:

❑ To be picked up by: Name: _____

❑ By mail at this address:

❑ By email at this email address:

❑ By fax at this number: ( )

Section G: Privacy Complaint

Describe your complaint and why you believe the practice or incident is improper:

Date you became aware of this issue: _____/_____/_____

Name and title of person(s) involved (if known):

Name: _____ Title:_____

Name: _____ Title:_____

Has this complaint been filed with the Department of Health and Human Services?

❑Yes ❑No Date (if yes): _____/_____/_____

Section H: Signature (this section is required)

Name of Person completing form:

Phone number: ( )

Relationship to Patient*:

Signature: _____

Section I: For CHC Use Only

Received by: Name: _____ Date: _____/_____/_____

Completed by: Name: _____ Date: _____/_____/_____

Status: ❑Approved ❑Denied ❑Investigation completed

Date notice/resolution provided to Patient: _____/_____/_____

Note: If this is a request, it will not take effect until it is approved by the CHC. You'll be notified in writing of the CHC's decision.

*For purposes of this Authorization, all references to Culinary Health Center or CHC include the Neighborhood Health Center, LLC.

**If this form is submitted by a personal representative (e.g. someone who has authority under applicable law to act on someone's behalf, such as a legal guardian, executor, someone with durable power of attorney), please also submit proof of such authority.