The Office for Civil Rights (OCR)
ADA Sample Request for Access

APPENDIX 2.14.1: ADA SAMPLE REQUEST FOR ACCESS

This information is excerpted from the *ADA Complete HIPAA Compliance Kit*, a publication of the American Dental Association available at adacatalog.org or 800.947.4746.

This sample form illustrates how a dental practice might document a request for access to patient information.

Privacy Official Name: _____ Telephone: _____
Patient's Name (print):_____

Date of Birth: _____ (for identification purposes)

Describe the records you wish to access and the approximate dates of the records: _____
_____
_____

What would you like for us to do for you?

- ☐ I wish to see the requested records.
- ☐ I wish to get a copy of the requested records.
- ☐ I wish to see and get a copy of the requested records.
- ☐ If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records the following form and format, if readily producible:_____

  If you would like the information emailed, enter the email address here (PLEASE PRINT VERY CLEARLY!): _____@_____

  We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.
- ☐ I want you to prepare summary of the requested records and I agree in advance to pay a fee in the amount of $_____.
- ☐ I want you to prepare an explanation of the records that I saw or got a copy of, and I agree in advance to pay a fee in the amount of $_____.
- ☐ I want you to send the copy of the requested records to:

  Name: _____

  Address: _____

Fees
Our practice charges a reasonable, cost-based fee to for copies of patient information, and for postage to mail records if requested.

Questions?
Please contact our privacy official listed at the top of this page if you have any questions about your request to inspect or copy records.

If the request is by a patient:

Patient Signature: _____ Date: _____

If the request is by a patient's personal representative:

Print the Name of the Personal Representative: _____

Relationship to the Patient: _____

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: _____

For dental office use only:

- ☐ Request for access denied (attach written denial).
- ☐ Request for access approved.

If approved, describe below when and how access was provided. If an electronic copy was provided, describe the form and format of the electronic copy.

_____