REQUEST TO DIRECT ELECTRONIC PROTECTED HEALTH INFORMATION (PHI) TO THIRD PARTY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1978 (9-2022)

Clear Fields

Through the HIPAA Right of Access, you (or your legal representative) have the right to request a Department of Health and Human Services (Department) health plan, health care facility, or program providing health care send a copy of your protected health information (PHI) directly to a third party (person or entity) designated by you. The Department is only required to comply with your request if the Department maintains your PHI electronically. The Department will provide the copies of your PHI to the third party in the form and format requested if the PHI is readily producible in such form and format. Otherwise, the PHI will be provided in a readable hard copy form, or another form or format determined by the Department depending upon the method of delivery requested.

You must clearly identify the designated third party to receive the PHI and where to send the PHI. A separate request must be made to each Department health plan, health care facility, or program providing health care. The Department will respond to your request within 30 days from the receipt of your request. The Department may charge you a fee for sending a copy of your PHI to the designated third party and may require fees be paid in advance. The Department may verify the identity and authority of any person making a request.

Special Notice Regarding Substance Use Disorder Information: Substance use disorder information is protected by federal confidentiality rules, 42 C.F.R. part 2. The federal rules prohibit the Department from disclosing your substance use disorder information to the designated third party unless a valid authorization form permitting the disclosure of the substance use disorder information to the designated third party is attached to this form or is already on file with the Department.

CLIENT INFORMATION

Client Name (Last, First, Middle Initial)			Date of Birth
Previous Names Used			
Address	City	State	ZIP Code
Name of the Department Health Plan, Health Care Facility, or Program Providing Health Care			
Telephone Number (if we have questions regarding your request)			

Dates of PHI Associated with Your Request
From: To:

Specify the PHI Below (be as specific as possible)

DESIGNATED THIRD PARTY

Identify the person/entity to receive the PHI. Please print clearly and verify the information provided is accurate.

First and Last Name of Person or Name of Entity to Receive the PHI

FORMAT AND DELIVERY METHOD:

The Department may charge you a fee for providing copies of your PHI to the designated third party, which may include the cost of labor, supplies, and postage.

Special Notice Regarding Email: If you chose to have the PHI sent to the designated third party by email, be advised that emails from the Department will be sent by encrypted (secure) email. The privacy and security of emails cannot be guaranteed. There is risk that PHI contained in emails may be misdirected, disclosed to, or intercepted by an unauthorized recipient. The Department will rely on the contact information you provide. The Department is not liable for emails that are not received due to technical failure or for improper disclosures of PHI. The Department is not responsible for any fees imposed by the designated third party's email service provider. You should not agree to send the PHI by email unless you are willing to accept these risks. Your signature on this document is your consent for the Department to send the PHI to the designated third party through encrypted (secure) emails. Your consent applies only to emails regarding this request to send PHI to the designated third party. Emails may be included in your Department record.

Select the format and delivery method of the PHI below (check only one). Please print clearly and verify the information provided is accurate.

☐ Mail PHI To:	Address	City	State	ZIP Code
☐ Email PHI To:		Email Address		

All requests must be signed and dated. If you are signing this form as a legal representative other than a parent of a minor child, you must attach documentation that establishes your legal authority to act on behalf of the client if not already on file with the Department.

Signature of Client or Legal Representative	Date
If Legal Representative, Print Name	Relationship to Client

FOR DEPARTMENT USE ONLY

Date Request Received by Department		
Does PHI include substance use disorder information? (check only one) ☐ No ☐ Yes, Authorization on File ☐ Yes, No Authorization on File, SUD Information Excluded		
Comments		
Printed Name of Department Representative	Signature	Date Completed