



**REQUESTS CONCERNING PROTECTED HEALTH INFORMATION (“PHI”)  
Access / Amend / Restrict / Revoke Authorization / Accounting / Manner of Contact  
City of Henderson, Nevada (“COH”)**

Individual’s Name: \_\_\_\_\_

Individual’s Address: \_\_\_\_\_

Individual’s Birth Date: \_\_\_\_\_ Date Request Submitted: \_\_\_\_\_

**Request:** I request the following, as permitted by Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) and the HIPAA Privacy Rule. *(Check all that apply, provide information above/below and sign below, and provide information on pages 3-6, as applicable.)*

- 1.  Access, review, and/or receive copies of the above Individual’s PHI.  
*(Go to page 3 and provide information under “1.”)*
- 2.  Amend the above Individual’s PHI. *(Go to page 4 and provide information under “2.”)*
- 3.  Restrict or limit the use or disclosure of the above Individual’s PHI.  
*(Go to page 5 and provide information under “3.”)*
- 4.  Revoke a prior authorization to use or disclose the above Individual’s PHI.  
*(Go to page 5 and provide information under “4.”)*
- 5.  Accounting of disclosures of the above Individual’s PHI.  
*(Go to page 6 and provide information under “5.”)*
- 6.  To be contacted at a different place(s) or in a different way.  
*(Go to page 6 and provide information under “6.”)*

**BY COMPLETING THIS REQUEST FORM AND SIGNING BELOW, I acknowledge and warrant that I have reviewed and understand the information contained on all pages in this form, that I am competent and authorized to fill out, sign, and submit this form, that I have provided full, complete, and accurate information, and that I freely and voluntarily sign and submit this form. I understand that I can contact COH at 702.267.HIPA (4472), if I have any questions about filling out/submitting this form.**

Signature (Individual or Personal Representative): \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

*(If signed by someone other than the Individual, state your relationship to the Individual (such as, Health Care Power of Attorney, Parent, Guardian, Executor of Estate, etc.). Otherwise, insert “Self.”)*

Personal Representative Name (if applicable): \_\_\_\_\_

Personal Representative Signature (if applicable): \_\_\_\_\_



In accordance with the rights granted by the HIPAA Privacy Rule, I am submitting the request(s) as indicated on the front of this request form and providing the additional information below, as required and applicable. I understand that COH will retain as a record this request form, COH's response, and associated documentation in accordance with HIPAA and the HIPAA Privacy Rule.

*After fully completing and signing this request form, submit the signed form and Personal Representative documentation (if person other than the Individual is signing request form) to COH at:*

In Person: Henderson City Hall *(Regular, non-holiday business hours are Monday - Thursday, 7:30 a.m. to 5:30 p.m. Pacific time)*  
City Clerk's Office  
240 S. Water St.  
Henderson, NV 89015

By Email: HIPAAprivacy@cityofhenderson.com *(Please remember that communication by unencrypted email presents a risk that personally identifiable information contained in such an email may be intercepted by unauthorized third parties.)*

By Mail: City of Henderson  
Henderson City Hall  
Attn: HIPAA Privacy Officer  
P.O. Box 95050, MSC 136  
Henderson, NV 89009-5050

*[FORM CONTINUES ON PAGES THAT FOLLOW]*

**1. REQUEST FOR ACCESS, TO REVIEW, AND/OR TO RECEIVE COPIES OF THE INDIVIDUAL'S PHI:**

I understand that I have the right to inspect or receive a copy of the above Individual's PHI, that COH may deny some or all of this request for specific reasons as outlined in the HIPAA Privacy Rule, and that COH will notify me in writing of the decision regarding this request. I request that access to the PHI for the above Individual be provided as follows:

**Description of PHI being requested** (including description of information and any date range):

---

---

---

**Designated recipient** (*first and last name, title (if any), business name (if any)*), **manner of accessing** (*e.g., review or pick up copies during regular hours at City Hall and/or have copies mailed, faxed, or emailed*), and **where to send/provide access to PHI** (*e.g., mailing address, fax number, or email*): \_\_\_\_\_

---

**Designated recipient, manner of accessing, and where to send/provide access to PHI:** \_\_\_\_\_

---

**Designated recipient, manner of accessing, and where to send/provide access to PHI:** \_\_\_\_\_

---

---

**2. REQUEST TO AMEND THE INDIVIDUAL'S PHI:**

I hereby request an accounting of disclosures. understand that I have the right to have PHI in the designated record set of the above individual amended when that information is inaccurate or incomplete, that COH might or might not amend the PHI based on my request, that the original information in the record will not be altered, and that COH will notify me in writing of its decision regarding this request.

I request that the following information be amended in the above Individual's medical record:

Date(s) of Entry to be amended: \_\_\_\_\_

Description of Information to be corrected or amended: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Description of how entry(ies) should read to be more accurate or complete: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason(s) supporting the requested amendment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Additional pages may be attached if more space is needed. If possible, please enclose with this request copies of the specific information to be corrected or added.*

*COH has 60 days to respond to the amendment request from the date of receipt. If COH is unable to act on the request within 60 days, an extension of 30 days may be required. If an extension is required, COH will notify you and provide a written explanation of the delay. COH will notify you in writing if the request is accepted or denied.*

**If the request is approved, I hereby authorize COH to provide copies to persons who received this PHI from COH and to the following (Specify each person's name, title, and mailing address):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. REQUEST TO RESTRICT OR LIMIT THE USE OR DISCLOSURE OF THE INDIVIDUAL'S PHI:**

I understand that I have the right to request that COH restrict or limit the use or disclosure of the above Individual's PHI, that COH does not guarantee that it will agree to this request, and that, if COH does agree to this request for restriction, then COH will not use or disclose the PHI in violation of the agreed-to restriction unless the restricted PHI is required to provide emergency treatment to the above Individual. I understand that an agreed-to restriction is not effective to prevent certain uses and disclosures that are permitted or required under the HIPAA Privacy Rule. I also understand that I may terminate the agreed-to restriction orally or in writing and that COH may terminate its agreement to the restriction.

I request that COH restrict/limit the use or disclosure of the Individual's PHI as follows (*Specify the nature of the restriction or limitation being requested*): \_\_\_\_\_

---

---

---

---

---

---

**4. REQUEST TO REVOKE A PRIOR AUTHORIZATION TO USE OR DISCLOSE THE INDIVIDUAL'S PHI:**

As further specified below, I hereby revoke the written authorization that the above Individual provided, giving COH permission to use PHI for specified purposes and/or to disclose PHI to a third party(ies) specified by the Individual in that authorization. I understand this revocation does not apply to uses or disclosures already made under that authorization that is not being revoked/canceled. I understand COH will distribute this revocation to the appropriate COH covered units and business associates.

- Authorization revoked in its entirety.
- Previously authorized use(s) and/or disclosure(s) of PHI are being revoked as follows:

---

---

---

---

---

---

---

---

---

---

**5. REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF THE INDIVIDUAL’S PHI:**

I understand that I have the right to know who received my PHI when I didn’t authorize the disclosure or when it was made for reasons other than treatment, payment, or health care operations. I understand that COH will provide me with a report of all disclosures of my PHI unless the disclosure fits within an exception to the accounting requirement. I hereby request that COH provide the following accounting:

- All disclosures of my PHI made by COH.
- Disclosures of my PHI made by COH during the following time period: \_\_\_\_\_

*COH has 60 days to respond to the request for an accounting from the date of receipt. If COH is unable to act on the request within 60 days, an extension of 30 days may be required. If an extension is required, COH will notify you and provide a written explanation of the delay.*

**6. REQUEST TO BE CONTACTED AT A DIFFERENT PLACE OR IN A DIFFERENT WAY:**

I understand that I can make reasonable requests to be contacted at a different place or in a different way. For example, I can ask to have the COH Fire Department call me at my office regarding my ambulance transport instead of my home or to have the COH Accounts Receivable Division to send my ambulance transport bill to me by mail in an envelope instead of on a postcard.

I also understand that, if I request that COH contact me by email, COH will send that email to me encrypted.

Accordingly, I request to be contacted by COH in the following manner:

- Home phone at: \_\_\_\_\_
  - Do or**  **Do Not** leave a detailed messages left on my answering machine/voicemail.
- Work phone at: \_\_\_\_\_
  - Do or**  **Do Not** leave a detailed messages left on my answering machine/voicemail.
- Mobile phone at: \_\_\_\_\_
  - Do or**  **Do Not** leave a detailed messages left on my answering machine/voicemail.
- By mail (United States Postal Service) at the following address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- By email at: \_\_\_\_\_
- By facsimile at: \_\_\_\_\_

I have the following additional request regarding receiving communications of the Individual’s PHI:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



<b>For City of Henderson use only:</b>	
Request received by <sup>1</sup> : _____	Date Received: _____
Requestor notified in writing of delay in COH response by <sup>1,2</sup> : _____	Date Notified: _____
Personal Representative Documentation provided <sup>3</sup> : _____	Date Provided: _____
Requestor notified in writing of COH response by <sup>1</sup> : _____	Date Notified: _____
COH Control #: _____	

<sup>1</sup> Fill in COH employee first name, last name, and ID number or insert "N/A" if not applicable.

<sup>2</sup> For a request under **1** (access), **2** (amend), or **5** (accounting of disclosures of PHI), one extension of up to 30 days is permitted if, before COH's response is due, COH informs the requestor in writing of the reasons for the delay and the date by which COH will respond to the request. Use Form 8.0.2 (Notice of Delay in Responding to Request for Access to PHI, Correction/Amendment of PHI, or Accounting of Disclosures of PHI).

<sup>3</sup> Identify documentation provided (see Table 8.1 in HIPAA Policy Manual) or insert "N/A" if not applicable.