Division of Services for People with Disabilities

HIPAA Information Request Form

Mail, fax, or email to:
DSPD Records Compliance Officer
195 North 1950 West
Salt Lake City, Utah 84116
dspddocuments@utah.gov
Fax: 801-538-4279

Per the Health Insurance Portability and Accountability Act (HIPAA), you have the right to make requests on your Personal Health Information (PHI) on the Division of Services for People with Disabilities (DPSD) records. DSPD will then evaluate all requests and will either grant or explain the reason why a request was declined. **Please complete this form, have it notarized, and submit it to DSPD's records compliance officer.**

Today's Date: / /	First Name:	Last Name:
Street Address:		

City:	State:	Zip Code:

Home Phone: ( ) -	Work Phone: ( ) -
Fax *(if available)*: ( ) -	Email Address *(if available)*:

Are you completing this request form on behalf of someone else? *(check one)*

☐ **Yes**   ☐ **No**

If Yes, what is your name and relationship to the person?

First Name:	**Last Name:**	**Your Relationship:**

Type of Request: *(check all that apply)*

☐ View my PHI as available in DPSD's records/case file
☐ Get copies of my PHI as available in DSPD's records/case file
☐ Update my PHI
☐ Correct / Delete existing PHI
☐ Place limits on uses and disclosures of my PHI
☐ Receive list of disclosures of PHI made by DSPD
☐ Change how DSPD sends PHI to you (i.e. select alternative address)

Please be specific and describe in detail the nature of your request:

If appropriate, attach a copy of all supporting documentation to this request form.

Signature: _____   Date: ____/___/_____

Insert Notary here:

HIPAA Information Request Form

For Internal Use Only:

Date Request Received: / /	
Has the request been approved: Yes ☐ No ☐	
If <u>Yes</u>, describe how the request will be met:	
If <u>No</u>, describe why the request has been declined:	
Additional comments by HIPAA Compliance Officer *(if applicable):*	
Date Request Approval/Denial Submitted: / /	

_____ _____
HIPAA Compliance Officer   Date