HOUSE OF NEW HOPE
8135 Mount Vernon Road
Saint Louisville, Ohio 43071

HIPAA Privacy Rights Request Form

CLIENT INFORMATION

Date

Name (Last, first, middle initial)

Social Security #

Street address, City, ST, ZIP Code

Primary phone number | Other phone number

Email address

Type of Request

- ☐ Access/copy
- ☐ Amendment
- ☐ Restriction
- ☐ Confidential communication
- ☐ Accounting of disclosures
- ☐ Complaint

Please describe nature of action requested (type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) **in detail**.

[Note: If this is an alternative communications request, please list alternative location/address for receiving medical information below.]

Please list staff members that were contacted regarding this matter:

Name | Date

Name | Date

Client or Legal Guardian Signature | Date

For Administrative Use Only:

Date received

Action taken

Date

Action taken

Date

Privacy Official signature | Date

Attach additional documentation, if applicable.