

NC Division of State Operated
Healthcare Facilities

Broughton Hospital

Request for Accessing/Inspecting/Copying Health Information

Client Identification

(Copy of DL or Identification Card Required)

*Client Name: Leonard Clinton Williams III * Date of Birth: 11/01/1980 MR #: _____
Address: 13009 Yorkridge dr apt 214 Charlotte NC 28273
Street Apt # City State Zip
Home Phone #: (980)-613-2196 Wk. Phone #: (NA)

Guardian/Family Member Identification

(Proof of Guardianship Required)

Guardian/Family Member Name: _____
*Address: _____
Street Apt # City State Zip
Home Phone #: () Wk. Phone #: ()

Request for Access/Inspect/Copy

I hereby request to ☒ Access/Inspect
☐ Copy

The specific information to be disclosed all legal and illegal requests for my medical records and all legal and illegal sending out of my medical records

for the period of time from July 1st, 1999 to March 18th, 2021

I understand there is specific health information to which this agency may deny access, without my having an opportunity for review, as follows:

- Psychotherapy Notes
- Information compiled for civil, criminal or administrative action or proceeding
- Health information subject to the Clinical Laboratory Improvement Amendments of 1988
- Information created or obtained in ongoing research that includes treatment if this was a condition of participation in the research; denial of access without an opportunity of review will be removed at the conclusion of the research
- Records that are subject to the Privacy Act, 5U.S.C. 522a
- Health information obtained under a promise of confidentiality

I further understand there may be circumstances when a licensed health care professional may deny my request for access to my health information; and that I am allowed to request a review by another licensed health care professional.

Client _____ Date/Time 11/13/21
Guardian/Family Member _____ Title (If Personal Representative) or Agency _____ Date/Time

*Required Fields

Request Determination on Reverse Side

Health Information Disclosed

Broughton Hospital

(Date)

(Signature of Staff)

This Section for Agency Use Only

Review of Request

Determination:	<input type="checkbox"/> REQUEST APPROVED
Agency Responsibilities:	<input type="checkbox"/> Determination of method for client access <input type="checkbox"/> Notice to client of approved access <input type="checkbox"/> Offer client summary of information <input type="checkbox"/> Notify client of requirements for copies of health information
Determination:	<input type="checkbox"/> REQUEST DENIED
Reason for Denial:	<input type="checkbox"/> Reference made to another person could endanger that person <input type="checkbox"/> Access could endanger life or physical safety of client or other(s) <input type="checkbox"/> Access requested by personal representative and access cause substantial harm to client or other(s) <input type="checkbox"/> Other _____
Agency Responsibilities:	<input type="checkbox"/> Written notice to client of basis for denial <input type="checkbox"/> Provide client with opportunity to request review by licensed health care professional in agency <input type="checkbox"/> Provide client with opportunity to request record be sent to a physician or psychologist of his/her choice
_____ Attending Physician/Agency Director or Designee	
_____ Date	

Request Denied-Second Review

Determination:	<input type="checkbox"/> REQUEST APPROVED
Agency Responsibilities:	<input type="checkbox"/> Determination of method for client access <input type="checkbox"/> Notice to client of approved access <input type="checkbox"/> Offer client summary of information <input type="checkbox"/> Notify client of requirements for copies of health information
Determination:	<input type="checkbox"/> REQUEST DENIED
Reason for Denial:	<input type="checkbox"/> Reference made to another person could endanger that person <input type="checkbox"/> Access could endanger life or physical safety of client or other(s) <input type="checkbox"/> Access requested by personal representative and access could cause substantial harm to client or other(s) <input type="checkbox"/> Other _____
Agency Responsibilities:	<input type="checkbox"/> Written notice to client of basis for denial <input type="checkbox"/> Provide client with contact information for US DHHS Secretary

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Agency Licensed Health Care Professional

Date