1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

# Individual Request for Access to Protected Health Information (Sparrow Laboratories)

As provided by the Health Insurance Portability and Accountability Act (HIPAA) and applicable Michigan law, you have a right of access, with certain exceptions, to inspect and obtain a copy of your health information contained in a designated record set. This right does not apply to:

- Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and

As further provided by HIPAA and Michigan law, under certain circumstances, Sparrow Hospital (or Sparrow Laboratories) may deny a patient (or other requestor) access to certain protected health information.

Specific type of information to which you request access:

☐ Sparrow ☐ Clinton ☐ Ionia ☐ Carson City ☐ Eaton ☐Sparrow Specialty Hospital

Indicate the format in which you would like to receive your requested information.

☐ My Sparrow Account ☐ Electronic Copy (CD) ☐ Paper Copy ☐ On-site Inspection
☐ In-Person Pickup ☐ Mail ☐ Fax ☐ Email

Description of information: all test results for Date of Service: ___________________________________

Sparrow Health System (or Sparrow Laboratories) will act on this request within 30 business days of the date listed above or, within an additional 30 days if the requested information is not maintained or accessible to Sparrow Health System (or Sparrow Laboratories) on-site. You will be informed either of the acceptance of the request and be provided with the requested access, or you will receive a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed under applicable law.

______________________________________________
Printed name of patient or patient's representative

______________________________________________ ________________________
Signature of patient or patient's representative Date Time

Complete only if patient or representative signs by use of a mark:

______________________________________________
Printed name of witness

______________________________________________ ________________________
Signature of witness Date Time

______________________________________________
Printed name of witness

______________________________________________ ________________________
Signature of witness Date Time

*[If the above signature is that of a patient's representative, Sparrow must complete the following.]*

Sparrow Health System has verified the identification of ____________________________________ (patient's representative name) by __________________________________________ (type of verification, e.g., driver's license) and that in his/her capacity of ___________________________________(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

______________________________________________ ________________________
Verification completed by (Caregiver name and signature) Date Time