South Carolina Department of Social Services

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

I hereby request the Department of Social Services (DSS) to provide me with access to my protected health information maintained by DSS. Specifically, I would like to:

❑ Inspect my protected health information for the time period

from _____ to _____,

or only the following portions:

_____.

❑ Obtain a copy of my protected health information.

I understand that the right to access this information does not include psychotherapy notes; information needed for some legal proceedings; information provided under the promise of confidentiality where access is likely to reveal the source; or, when the DSS determines that my access is reasonably likely to endanger my life or another person's life or physical safety. I understand that in such cases, DSS may deny my access to this information.

I understand that DSS will normally provide access within 30 days of receipt of my request, but if it will take longer, DSS will notify me in writing and explain the reason for the delay and the date action will be taken.

I understand that I may be charged a fee for copying costs to obtain a copy of my protected health information, as well as mailing costs if I want it mailed to me.

_____ _____

Signature of Client or Representative Date

_____

Printed Name

_____

Relationship of Representative to Client