Department *of* Health & Human Services Services for People with Disabilities

Mail, fax, or email to:
DSPD Records Compliance Officer 288 North 1460 West
Salt Lake City, Utah 84116
dspddocuments@utah.gov
Fax: 801-538-4279

Division of Services for People with Disabilities

HIPAA Information Request Form

Version: October 2025

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 and submit it to DSPD's records compliance officer.**

Privacy Notice: See the end of this form to learn why DHHS collects this information

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: ____ ____ _____

HIPAA Information Request Form

For Internal Use Only:

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

HIPAA Compliance Officer **Date**

PRIVACY NOTICE: The information you provide will be used to review and process HIPAA information requests. It will only be used by DHHS and, if needed, by individuals or parties contracted with DHHS. Without this data we cannot review and process HIPAA information requests. This data is part of record series: 15376.