



**Access Request—Avert Serious Threat  
to Health or Safety  
Hillsborough County  
Access to Protected Health Information (PHI)  
for Averting a Serious Threat to Health or Safety**

**Directions:** This form is to be used whenever there is a request for access to an individual's protected health information for the purpose of averting a serious threat to health or safety. Its contents should be entered into the HIPAA compliance system by your Privacy Liaison. The form should also be filed with the patient's records.

Read this page carefully and sign the access request to confirm that you understand its content.

Date: \_\_\_\_\_

Provide the Name, Title, Organization, and Phone Number of Person Making Request:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

We are requesting records for:

Individual's full name: \_\_\_\_\_

SSN or other patient identifier: \_\_\_\_\_

**Hillsborough County, in good faith, believes the use or disclosure of protected health information:**

- Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or
- Is necessary for law enforcement authorities to identify or apprehend an individual:
  - Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or
  - Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody; and the protected health information
- Was not obtained:
  - In the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure, or counseling or therapy; or
  - Through a request by the individual to initiate or to be referred for the treatment, counseling, or therapy described above.



Mark the information below that is being disclosed.  
*Hillsborough County will provide only the information required by the blanks below.*

Name \_\_\_\_\_

Address \_\_\_\_\_

Birth date \_\_\_\_\_ and birth place \_\_\_\_\_

Social Security number \_\_\_\_\_

ABO blood type and Rh factor \_\_\_\_\_

Type of injury \_\_\_\_\_

Date \_\_\_\_\_ and time \_\_\_\_\_ of treatment.

Distinguishing characteristics \_\_\_\_\_

\_\_\_\_\_

Verification of requestor identity: \_\_\_\_\_

Verification of requestor authority (if applicable): \_\_\_\_\_

Print name of requestor: \_\_\_\_\_

**Original signature of requestor:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

Original signature of Hillsborough County staff providing information:

\_\_\_\_\_

Date: \_\_\_\_\_

<p><i>For internal use only:</i>  Date Received: _____  Recipient: _____</p>
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