

**STATE OF CONNECTICUT**  
**Office of Health Care Access**  
**Freedom of Information**  
**Hospital Inpatient / Emergency Department Discharge Data Request Form**

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

The Office of Health Care Access (OHCA) maintains an acute care hospital inpatient discharge database, has access to ChimeData emergency department database and fills requests for aggregate health data from all interested individuals, institutions and other government agencies. Data released to interested parties however are subject to the provisions of section 19a-167g-94 of OHCA's Budget Review Regulations and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and other local, state and federal regulations relating to the maintenance of patient privacy.

Fees may be associated with responding to these requests. Only request forms that are fully completed will be considered. Discharge categories with fewer than six patients will be noted as less than six (<6).

For more information, contact OHCA at (860) 418-7001 or [ohca@ct.gov](mailto:ohca@ct.gov),

After submitting your request, you will be notified within four (4) business days whether: 1) the request has been approved for preparation, 2) the request has been denied because it involves confidential information or does not meet required thresholds, or 3) it cannot be readily determined until the report is prepared whether or not it meets required thresholds.

Please review Section 19a-167g-94 of OHCA's regulations (especially section (g) on pages 87-92) for an overview of the data request process, data elements collected, confidential data elements, and required thresholds **before** completing this request form.

**INFORMATION REQUESTED – (PLEASE FILL OUT ALL INFORMATION AND ATTACH ADDITIONAL PAGES IF MORE SPACE IS REQUIRED)**

- 1. LIST OF DATA ELEMENTS TO BE INCLUDED:**
  
  
  
  
  
  
  
  
  
  
- 2. DATA SELECTION CRITERIA (e.g., specific ICD-9-CM codes, DRG codes, demographic variables, or at least two contiguous zip codes, if zip code information is being requested):**
  
  
  
  
  
  
  
  
  
  
- 3. TIME PERIOD FOR REQUESTED DATA** (*Fiscal years available: Inpatient 1991– 1<sup>st</sup> 6 months 2012, Emergency Department 1996-2010*)

**4. SAMPLE REPORT LAYOUT (Must be attached):**

**SELECT TYPE OF MEDIA AND FORMAT FOR REPORT:**

**5. MEDIA**

- E-mail
- Paper Report
- CD-ROM

**Format**

- MS EXCEL (.xls)
- ASCII (.txt)

**6. Return Request by: (Please check one)**

- E-mail**
- Fax**
- Pick Up**
- Mail**

*Submission of this form serves as confirmation that the request conforms to the confidentiality provisions of Office of Health Care Access regulations.*

**Requestor Information:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Company

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Town, State and Zip Code

\_\_\_\_\_  
Telephone **and** Fax Number

\_\_\_\_\_  
Email Address

**Your bill for this service is:**

Files on CD @ \$5.00 per file	\$
Paper Copies @ \$.25/page	\$
Programming and formatting fee @ \$9.39/quarter hour	\$
Postage & Shipping Charges (if applicable)	\$
<b>Total Amount Due</b>	<b>\$</b>

**Payment:** PLEASE MAKE CHECKS PAYABLE TO "TREASURER, STATE OF CONNECTICUT" AND REMIT TO THE OFFICE OF HEALTH CARE ACCESS, 410 CAPITOL AVENUE, MS#13HCA, P.O.BOX 340308, HARTFORD, CT 06134 AS SOON AS POSSIBLE. **PLEASE BE SURE TO INCLUDE ONE COPY OF THIS BILL WITH YOUR PAYMENT.**