Dignity Health.
Saint Francis Memorial Hospital

900 Hyde Street,
San Francisco, CA 94109
Fax: 415-353-6316

# Exhibit A

## PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Date:_____M.R. # or Account #:_____

Patient Name:_____AKA/ other names: _____

Date of Birth:_____Phone:_____
Address:
_____City/State/Zip_____

Covering the period of healthcare from *(date)*_____(*date)*_____
You have requested access to health information about you. To enable us to process your request, please read the following carefully and complete the requested information below.

**There may be fees associated with your request.** The form in which you access your information may determine the amount of such fees.

A. You would like access to the health information about you maintained by *(Hospital, facility or clinic name)* as follows: *(Check one)*.

☐Inspect only
☐Copy only (*Fees may apply. See attached price list.)*
☐Paper
☐Electronic: ☐USB Drive ☐CD ☐Email _____
☐Other: _____
☐Inspect and copy *(Fees may apply. See attached price list.)*

☐Secure Email: _____
☐Unsecure Email:_____
****If requesting unsecured email, I understand that using unsecured email may place my PHI at risk, and accept the risk of sending my PHI via an unsecured mechanism.***

B. You may obtain the following in lieu of a copy of the medical records:
□Written summary of health information *(Fees may apply. See attached price list.)*

 

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C. Tell us which type of health information you want to access (Not Applicable for Online Patient Center) (Check all that apply):

☐ Complete Health Record(s)
☐ Discharge Summary
☐History and Physical
☐ Consultation Report
☐Billing Records
☐ Emergency Room Records
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray Reports
☐Others *(please specify)* _____

**D. ONLINE PATIENT CENTER/PATIENT PORTAL ACCESS ONLY**

Email Address: _____

**E.** Patient's Right to Direct Health Information to another person. You have the right to ask us to send your health information to a person of your choice. We need that person's name and full address. Please give that person's name and full address here:

_____
Print Person's Name

_____
Print Address

_____
Print City, State, Zip Code

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances or access may require consultation with your physician or healthcare provider responsible for your care before release. If you are requesting access to records relating to any of the following, please initial each applicable item to confirm your request.

**Arizona Dignity Health Facilities:**

_____Mental health records (excludes "psychotherapy notes")
_____Substance abuse treatment records
_____HIV related information and other communicable diseases.
_____Genetic testing information

 

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**California Dignity Health Facilities**

_____Mental health or developmental disability treatment records (excludes "Psychotherapy notes")

_____Substance abuse treatment records

_____HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status even if you do not initial this line.)**

**Nevada Dignity Health Facilities:**

_____Mental health (excludes "psychotherapy notes")

_____Substance abuse treatment records

_____Genetic testing information

All patients' (or personal representative's) request(s) for access to their health information are processed in the order received. Upon the hospital's receipt and review of your request, we will contact you with either denial or acceptance of the request. If your request is accepted we will contact you for a time and place when and how you may inspect and/ or obtain a copy of the records requested.

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**I have read and confirm the terms of access stated herein.**

_____ _____
Patient or Personal Representative's Signature Date

_____ _____
Print Name if Other Than Patient Telephone#

_____ _____
Relationship to Patient or Personal Representative ID Presented

_____ _____
Name of hospital employee verifying signatory information Title and Department

_____ _____
Patient Directed Right of Access - Pick up Signature Date

 