70.8.006 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 to access the health information about you maintained by (check all that apply):

☐ Arroyo Grande Community Hospital ☐ French Hospital Medical Center

☐ Marian Regional Medical Center ☐ Other:_____

B. Identify how you would like to access the health information:

☐ Inspect only

☐ Copy only (fees may apply)

☐ Paper

☐ Electronic: ☐ USB Drive ☐ CD ☐ Email ☐ Other:_____

☐ 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 unsecured mechanism.**

☐ Inspect and copy (fees may apply)

C. You may obtain the following in lieu of a copy of the medical records:

☐ Written summary of health information (fees may apply)

D. Tell us which type of health information you want to access, not applicable for Online Patient Center (check all that apply):

☐ Complete Health Records ☐ Emergency Room Records

☐ Discharge Summary ☐ Progress Notes

☐ History and Physical ☐ Laboratory Tests

☐ Consultation Reports ☐ X-ray Reports

☐ Billing Records

☐ Others (please specify):_____

E. **Online Patient Center/Patient Portal Access Only**

Email Address:_____

ROI

Dignity Health.

F. 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 First and Last 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.

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 <u>even</u> 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	Phone Number
Relationship to Patient of Personal Representative	ID Presented
Name of Hospital Employee Verifying Signatory Information	Title and Department
Patient Directed Right of Access Pick-up Signature	Date

ROI

Dignity Health.