Patient's Request For Access To Protected Health Information

Date: _____ M.R. #: _____

Patient Name: _____ AKA/Other Names: _____

Date of Birth: _____ Phone: _____

Mailing Address: _____ City/State/Zip: _____

Covering the period of hospitalization from *(date)* _____ to *(date)* _____

You have requested access to health information about you. To allow 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. Identify how you would like access to the health information about you maintained by Dignity Health as follows (Check one).

☐ copy only *(Fees may apply. See attached price list.)*
☐ Paper ☐ USB Drive ☐ CD
☐ Secure Email: _____ ☐ Unsecured 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.
You may obtain the following instead of a copy of the medical records:
☐ written summary of health information *(special report requested by physician - summary)*

B. Tell us which type of health information you want to access (Check all that apply):

☐ See specific info below all records pertaining to date of service
☐ For my own use - - - - OR - - - - - ☐ For Doctor Follow-Up
☐ Procedure Report ☐ Emergency Room Records
☐ Discharge Summary ☐ Progress Notes
☐ History and Physical ☐ Laboratory Tests
☐ Consultation Reports ☐ X-ray Reports
☐ EKG
☐ Others *(please specify)* _____
☐ Itemized Billing

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 item that applies to confirm your request

_____HIV (Human Immunodeficiency Virus) Test Results **(To be released upon approval of your physician.)**
Initial
_____Psychiatric care **(To be released upon caregiver's approval.)**
Initial
_____Treatment for alcohol and/or drug abuse
Initial

☐ MGH
☐ MHF
☐ MSJ
☐ MTH
☐ SNM
☐ WMH

Dignity Health.

PATIENT'S REQUEST FOR ACCESS TO PHI

ROI

SPSSSA20015
(09/22) SPS.INDD

Patient Identification

Place Patient Label Here

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.

This request for access will not require Dignity Health to provide health information about you to anyone other than to you or your personal representative. If you request us to disclose health records or information about you to some other person, we may need a signed authorization **(a different form)** from you to allow us to transmit such information.

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Return Address:
3400 Data Dr. Suite 1064
Rancho Cordova, CA 95670

Return Address:
155 Glasson Way
Grass Valley, CA 95945

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 of Personal Representative	ID Presented
Name of hospital employee verifying signatory information	Title and Department

NOTIFICATION TO DOCTOR: ______________________________
Your patient has requested copies of their medical record. State / federal laws permit you to deny access in certain circumstances. Please notify us by ______ if you wish to deny access, otherwise we will provide copies of the record.

DATE RECORDS RELEASED/SENT: ______________________________

PERSON RELEASING RECORDS: ______________________________

CHW Policy 9.806

Patient Identification

Place Patient Label Here