

**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.)

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.)

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

- |  |   |
|--|---|
| <input type="checkbox"/> Complete Health Record(s)     | <input type="checkbox"/> Emergency Room Records |
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Progress Notes         |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Laboratory Tests       |
| <input type="checkbox"/> Consultation Reports          | <input type="checkbox"/> X-ray Reports          |
| <input type="checkbox"/> Billing Records               |   |
| <input type="checkbox"/> 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 First Last Name

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Print City, State, Zip Code



**Dignity Health**  
St. Joseph's Hospital and  
Medical Center

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TO PROTECTED HEALTH INFORMATION**



ROI

Patient Label

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.

- \_\_\_ Mental health records (excludes "psychotherapy notes")
- \_\_\_ Substance abuse treatment records
- \_\_\_ HIV related information and other communicable diseases.
- \_\_\_ 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 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 of Personal Representative

\_\_\_\_\_  
ID Presented

\_\_\_\_\_  
Name of hospital employee verifying signatory information

\_\_\_\_\_  
Title and Department

\_\_\_\_\_  
Patient Directed Right of Access – Pick up Signature

\_\_\_\_\_  
Date

**FOR PSYCHIATRIC OR MENTAL HEALTH RECORDS  
CAREGIVER'S APPROVAL TO RELEASE OF INFORMATION**  
(Hospital use only)

Approved

Approved, subject to the following restrictions: \_\_\_\_\_  
\_\_\_\_\_

Denied, reason for denial: \_\_\_\_\_  
\_\_\_\_\_

(NOTE: Access may only be restricted or denied if you believe that providing access is reasonable likely to endanger the life or physical safety of the patient.)

Signature: \_\_\_\_\_ Role: \_\_\_\_\_  
*(physician, psychologist, social worker)*

Date: \_\_\_\_\_ Telephone Number: \_\_\_\_\_



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