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) _____ to: (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.

Please note the return information and send accordingly: *(Check all that apply)*

- ☐ Chandler Regional Medical Center
- ☐ Mercy Gilbert Medical Center
- ☐ Dignity Health Center for Diabetes Dignity
- ☐ Health Weight Loss Clinic
- ☐ Wound Center

Please EMAIL hospital / Urgent care request to:
DignityHealth-AZ-ROI@commonspirit.org

Fax: CRMC, MGMC, SJHMC

602-294-5726

Radiology/Imaging fax to: 480-728-3989

Billing Records for HOSPITAL ONLY Email to: remotecoc@optum.com

- ☐ Ahwatukee Urgent Care
- ☐ Gilbert Urgent Care
- ☐ Maricopa Urgent Care
- ☐ Queen Creek Urgent Care
- ☐ Dignity Health Medical Group:

_____

PLEASE EMAIL ALL DHMG REQUEST TO:
DHMG-HIMMedicalRecords@commonspirit.org Fax 602-212-5290

Billing Records for **CLINICS ONLY** Email to:
PBSCustomerService@commonspirit.org
Fax: (602) 798-0809

A. Identify how you would like to access the health information.

- ☐ Inspect only
- ☐ Copy only (Fees may apply. See attached price list.)
- ☐ Inspect and copy (Fees may apply. See attached price list.)

B. Identify in what format you would like to receive the health information.

- ☐ Electronic: (Identify how you would like to receive the health information).
  - ☐ 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.**
- ☐ Paper

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

☐ Billing Records (Produced by Billing Dept.)	☐ Clinical Records
☐ Consultation Reports	☐ Diagnostic Images (Prepped by Radiology Dept.)
☐ Discharge Summary	☐ Emergency Room Records
☐ History and Physical	☐ Immunization (shot)
☐ Laboratory Tests	☐ Medication List
☐ Operations and Procedures	☐ Physical Therapy notes
☐ Progress Notes	☐ Complete Health Record
☐ **Pertinent/Abstract** – includes (History and Physical, Operation/Procedure reports, Discharge Summary, Progress notes, Consultations, Laboratory and Radiology tests, Cardiology reports, Immunization report and Emergency Room records.	

D. ☐ ONLINE PATIENT CENTER/PATIENT PORTAL ACCESS ONLY (Access to Patient Records)
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 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 even if you do not initial this line.)

Nevada Dignity Health Facilities:

_____ Mental health records (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.

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

CAREGIVER DENIAL OF ACCESS FORM

(Facility use only)

☐ Denied in whole
☐ Denied in part

Specify information which access is denied:

Reason for denial:

(NOTE: Access may be restricted or denied if you believe that providing access is reasonably likely to endanger the life or physical safety of the patient or another person; the information withheld was obtained from another person under a promise of confidentiality and disclosing it would likely reveal the source of that information; the information references another person and giving the patient access is reasonably likely to cause substantial harm to that person; the request is made by the patient's personal representative and the provision of access to the personal representative is reasonably likely to cause substantial harm to the patient or another person. For additional guidance on when access may be restricted or denied please consult with Local Legal Counsel or Facility Compliance Professional.)

Signature

Role: *(e.g., physician, psychologist, social worker)*

Date

Telephone:

A COPY OF THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.