

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.*)

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 | |

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

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 (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