

## 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) \_\_\_\_\_ 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.

A. You would like access to the health information about you maintained by **Dominican Hospital** 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.)*

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Santa Cruz, CA 95065

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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"/> Discharge Summary    | <input type="checkbox"/> Progress Notes  |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Laboratory Tests     | <input type="checkbox"/> X-ray Reports   |
| <input type="checkbox"/> Emergency Room Records        | <input type="checkbox"/> Consultation 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 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

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Dominican Hospital

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## 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

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**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: \_\_\_\_\_

