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 maintained by **Bakersfield Memorial Hospital**. 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.

1. Identify how you would like to access the health information:
   - □ Inspect only
   - □ Copy only (*Fees may apply*)
   - □ Inspect and copy (*Fees may apply*)

2. Identify in what method you would like to receive the health information:
   - □ Paper
   - □ USB Flash 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.

   - □ Other (please specify)

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

   - □ Complete Health Record(s)
   - □ Discharge Summary
   - □ History and Physical
   - □ Consultation Records
   - □ Emergency Room Records
   - □ *Other (please specify)*
   - □ Progress Notes
   - □ Laboratory Tests
   - □ Radiology Reports

4. **ONLINE PATIENT CENTER/PATIENT PORTAL ONLY**

   Email Address: _____

5. **Patient's Rights 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

6. 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 or developmental disability treatment records (excludes "psychotherapy notes")
Initial

_____ Substance abuse treatment records
Initial

_____ HIV test results (This authorizes disclosure of laboratory test results only. **Note** that your records may
Initial include information concerning your HIV status <u>even</u> if you do not initial this line.)

7. 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. If your request us 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

Dignity Health.
Memorial Hospital

PATIENTS REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION