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 St. Joseph's Behavioral Health Center as follows *(Check one).*

- ☐ inspect only
- ☐ copy only *(Fees may apply. See attached price list.)*
- ☐ 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 *(Check all that apply):*

- ☐ Complete Health Record(s)
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ Billing Records
- ☐ Emergency Room Records
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ X-ray Reports
- ☐ Others *(please specify)* _____

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

_____ H IV (Human Immunodeficiency Virus) Test Results **(To be released upon approval of your physician.)**
Initial

_____ Psychiatric care **(To be released upon caregiver's approval. See page 2)**
Initial

_____ Treatment for alcohol and/or drug abuse
Initial

Dignity Health.
St. Joseph's Behavioral Health Center
2510 North California Street
Stockton, CA 95204
(209) 461-2000

* R O I *

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

3-033 (Rev 10/13/10)

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.

This request for access will not require St. Joseph's Behavioral Health Center to provide health information about you to anyone other than to you or your personal representative. If you request us to disclose health records or information about you to some other person, we may need a signed authorization (a different form) from you to enable us to transmit such information.

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

FOR PSYCHIATRIC OR MENTAL HEALTH RECORDS

CAREGIVER'S APPROVAL TO RELEASE OF INFORMATION

The undersigned, the physician, licensed psychologist or social worker with a master's degree in social work, who is in charge of the patient _____ hereby ☐ approves ☐ disapproves the release of information and records to the patient or personal representative specified herein.

(NOTE: If disclosure is disapproved, give reasons below and note any restrictions to the release of records. No approval is required for release to patient's attorney, unless the request is for the use or disclosure of information given in confidence by the patient's family.)

_____

_____

Signature: _____ Degree: _____

Print Name: _____ Telephone: _____

(physician, psychologist, social worker)

Date: _____

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Stockton, CA 95204
(209) 461-2000

* R O I *

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

3-033 (Rev 10/13/10)