## 70.8.006 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:	
	City/State/Zip:	
Covering the period of healthcare from (date		
You have requested access to health informations please read the following carefully and comp	ation about you. To enable us to process your request, lete the requested information below.	
There may be fees associated with your remay determine the amount of such fees.	equest. The form in which you access your information	
☐ Arroyo Grande Community Hospital	nation about you maintained by (check all that apply): ☐ French Hospital Medical Center ☐ Other:	
B. Identify how you would like to access the I  ☐ Inspect only ☐ Copy only (fees may apply) ☐ Paper ☐ Electronic: ☐ USB Drive ☐ CD ☐	health information:	
☐ Secure Fmail:	☐ Unsecure Email:	
*If requesting unsecured email, I und PHI at risk, and accept the risk of ser ☐ Inspect and copy (fees may apply)  C. You may obtain the following in lieu of a co	lerstand that using unsecured email may place my nding my PHI via unsecured mechanism.  opy of the medical records:	
Center (check all that apply):  Complete Health Records  Discharge Summary History and Physical Consultation Reports	u want to access, not applicable for Online Patient  Emergency Room Records  Progress Notes  Laboratory Tests  X-ray Reports  request to 3215 Prospect Drive, Rancho Cordova,	
E. Online Patient Center/Patient Portal Ac	cess Only	

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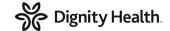


F. Patient's Right to Direct Health Information to another person. You have the right to ask us to sen your health information to a person of your choice. We need that person's name and full address. Please give that person's name and full address here:
Print Person's First and Last Name
Print Address_
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.) <b>Note that your</b>
records may include information concerning your HIV status <u>even</u> if you do not initial this line.
Nevada Dignity Health Facilities:Mental health (excludes "Psychotherapy Notes").
Substance abuse treatment records.
Genetic testing information.
All nationts' (or personal representative's) request(s) for access to their health information are

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.

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Patient or Personal Representative's Signature	Date
Print Name if Other Than Patient	Phone Number
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

I have read and confirm the terms of access stated herein.

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