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

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 records (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

CAREGIVER DENIAL OF ACCESS FORM

(Facility use only)

☐ Denied in whole
☐ Denied in part

Specify information which access is denied:

Reason for denial:

(NOTE: Access may be restricted or denied if you believe that providing access is reasonably likely to endanger the life or physical safety of the patient or another person; the information withheld was obtained from another person under a promise of confidentiality and disclosing it would likely reveal the source of that information; the information references another person and giving the patient access is reasonably likely to cause substantial harm to that person; the request is made by the patient's personal representative and the provision of access to the personal representative is reasonably likely to cause substantial harm to the patient or another person. For additional guidance on when access may be restricted or denied please consult with Local Legal Counsel or Facility Compliance Professional.)

Signature

Role: *(e.g., physician, psychologist, social worker)*

Date

Telephone:

A COPY OF THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.