# 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.

Please note the return information and send accordingly*:*

For Hospital Medical Records Only:

St. Rose Siena Hospital
PLEASE FAX REQUEST TO: 702-616-5235

St. Rose San Martin Hospital
PLEASE FAX REQUEST TO 702-492-8165

St. Rose DeLima Hospital
PLEASE FAX REQUEST TO 702-492-8165

Radiology/Imaging to :

St. Rose Siena and St. Rose DeLima:
Fax 702-616-5488 and Phone 702-616-5585

St. Rose San Martin:
Fax 702-492-8338 and Phone 702-492-8585

Dignity Health Medical Group -Nevada:

Blue Diamond
Henderson Clinic
Pavilion MultiSpecialty
Pavilion Primary Care
Pavilion Urgent Care
Peccole Plaza Clinic
San Martin Clinic
Siena MultiSpecialty
St. Rose Dream Fund Clinic
St. Rose Specialty Clinic-CVT
St. Rose Specialty Clinic-Neuro Surgery
Tivoli Village Clinic
West Flamingo Clinic

PLEASE SEND REQUEST TO:
DHMG-HIMMedicalRecords@DignityHealth.org

Or Fax to 602-212-5290

Billing Records: Send to
PBSCustomerService@DignityHealth.org
Or Send Fax to 602-798-0809

A. Identify how you would like to access the health information.

- ☐ Inspect only
- ☐ Copy only (Fees may apply. See attached price list.)
- ☐ Inspect and copy (Fees may apply. See attached price list.)

B. Identify in what format you would like to receive the health information.

- ☐ Electronic: (Identify how you would like to receive the health information).
  - ☐ USB Drive
  - ☐ CD
  - ☐ Email (list email address) _____
  - ☐ Paper _____

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

| | |
|---|---|
| ☐ Billing Records (Produced by Billing Dept.) | ☐ Clinical Records |
| ☐ Consultation Reports | ☐ Diagnostic Images (Prepped by Radiology Dept.) |
| ☐ Discharge Summary | ☐ Emergency Room Records |
| ☐ History and Physical | ☐ Immunization (shot) |
| ☐ Laboratory Tests | ☐ Medication List |
| ☐ Operations and Procedures | ☐ Physical Therapy notes |
| ☐ Progress Notes | ☐ Complete Health Record |
| ☐ Other | |

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.

**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 clinic's receipt and review of your request, we will contact you with either denial or a copy of the requested documentation. If your request to inspect we will contact you with a date, time and location to complete this.

**Patient Signature**

| | |
|---|---|
| Personal Representative's Signature | Date |
| Print Name if Other than Patient | Telephone # |
| Relationship to Patient of Personal Representative | ID Presented |
| Name of 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.**