

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 yourself. 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. Identify how you would like access to the health information about you maintained by St. Rose Dominican Hospitals as follows (check one):

- Inspect only
- Inspect and copy (Fees may apply)
- Copy only (Fees may apply):
 - Paper
 - Electronic: CD* USB ***Radiology Images are released by Radiology Department on CD only.**
 - Secure Email: _____ Unsecure Email: _____

Print Email Address
Print Email Address

*If requesting unsecure 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.

B. Tell us which type of health information you want to access (check all that apply):

- Pertinent information (Includes dictated reports, specialized tests, labs, xrays, and path reports)
- Complete Health Record(s)
- Consultation Reports
- Discharge Summary
- Laboratory Results
- History and Physical
- Radiology Reports
- Emergency Room Records
- Radiology Images on CD
- Itemized Billing
- Others (please specify) _____

C. ONLINE PATIENT CENTER/PATIENT PORTAL ACCESS ONLY

Email Address: _____

D. 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, City, State, Zip Code: _____



PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION



PATIENT IDENTIFICATION

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.

Dignity Health - St. Rose Dominican Hospitals (Nevada Dignity Health Facilities):

Initial _____ Mental health (excludes "psychotherapy notes") – To be released upon approval of your caregiver.

Initial _____ Substance abuse treatment records

Initial _____ Genetic testing information

Initial _____ HIV-related information and other communicable diseases

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.

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 or Personal Representative

ID Presented

Name of hospital employee verifying signatory info.

Title and Department

Patient Directed Right of Access - Pick up Signature

Date

**FOR PSYCHIATRIC OR MENTAL HEALTH RECORDS
CAREGIVER'S APPROVAL TO RELEASE OF INFORMATION**

(Hospital use only)

Approved

Approved, subject to the following restrictions: _____

Denied, reason for denial: _____

(NOTE: Access may only be restricted or denied if you believe that providing access is reasonably likely to endanger the life or physical safety of the patient.)

Signature: _____

Role: _____
(physician, psychologist, social worker)

Date: _____

Telephone Number: _____



PATIENT IDENTIFICATION

**PATIENT'S REQUEST FOR ACCESS TO
PROTECTED HEALTH INFORMATION**

