ROI02

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: _____

Address: _____

City/State/Zip: _____

Covering the period of healthcare from *(date)* _____ (*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 Dignity Health *(Check one)*

☐ Mercy Medical Center Redding ☐ St. Elizabeth Community Hospital
☐ Mercy Medical Center Mt. Shasta

B. Identify how you would like to access the health information:

☐ Inspect only
☐ Copy only *(Fees may apply. See attached price list.)*
☐ Paper
☐ Electronic: ☐ USB Drive ☐ CD ☐ Other: _____
☐ Secure Email: _____ ☐ Unsecured Email: _____

***If requesting unsecured 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.**

☐ Inspect and copy *(Fees may apply. See attached price list.)*

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

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

D. ❑ **ONLINE PATIENT CENTER / PATIENT PORTAL ACCESS ONLY**

Email Address: _____

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 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.

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.)

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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 of Personal Representative	ID Presented
Name of Hospital Employee Verifying Signatory Information	Title and Department
Patient Directed Right of Access - Pick up Signature	Date

Patient Label

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CAREGIVER DENIAL OF ACCESS FORM

(Facility use only)

☐ Denied in whole

☐ Denied in part
Specify information for 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 Number: _____

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

70.8.006 Exhibit A AZ CA NV– Rev: 082916

Billing Help Line
Dignity Health / HealthPort
(888) 488-7667

Patient Portal Help Line
(844) 274-8497
patientcenterstaff@dignityhealth.org

If requesting Itemized Billing records please forward your request to:
4425 East Cotton Center
Phoenix, AZ 85040

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