# 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 *(Hospital, facility or clinic name)* as follows: *(Check one)*.

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

B. You may obtain the following in lieu of a copy of the medical records:

- ☐ Written summary of health information *(Fees may apply. See attached price list.)*

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
- ☐ Billing Records
- ☐ Emergency Room Records
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ X-ray Reports
- ☐ Others *(please specify)* _____

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

Dignity Health.
St. Joseph's Hospital and Medical Center

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Patient Label

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.

____Mental health records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV related information and other communicable diseases.

____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 for a time and place when and how you may inspect and/ or obtain a copy of the records requested.

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**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

**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 reasonable likely to endanger the life or physical safety of the patient.)

Signature: _____Role: _____
*(physician, psychologist, social worker)*

Date: _____ Telephone Number: _____

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