

Date: \_\_\_\_\_ M.R. # or Account #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ AKA/Other names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

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 *Saint Francis Memorial Hospital* as follows (Check one).

- inspect only
- copy only (Fees may apply. See attached price list.)
- 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. **THE FOLLOWING RECORDS**, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

- Date(s): \_\_\_\_\_
- Billing Records
- Consultation Reports
- Discharge Summary
- Other: \_\_\_\_\_
- Emergency Room Reports
- History and Physical
- Laboratory Tests
- Procedure Reports
- Progress Notes
- X-ray Reports
- ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.

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.

\_\_\_\_\_ HIV (Human Immunodeficiency Virus) Test Results (To be released upon approval of your physician.)  
Initial

\_\_\_\_\_ Psychiatric care (To be released upon caregiver's approval. See page 2)  
Initial

\_\_\_\_\_ Treatment for alcohol and/or drug abuse  
Initial

Patient Request for Access to PHI  
CPDSA Approved - 2/21/03



900 Hyde Street • San Francisco, CA 94109 • (415) 353-6000

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



Patient Identification:

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.

This request for access will not require Saint Francis Memorial Hospital to provide health information about you to anyone other than to you or your personal representative. If you request us to disclose health records or information about you to some other person, we may need a signed authorization (a different form) from you to enable us to transmit such information.

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 \_\_\_\_\_

**FOR PSYCHIATRIC OR MENTAL HEALTH RECORDS**

**CAREGIVER'S APPROVAL TO RELEASE OF INFORMATION**

The undersigned, the physician, licensed psychologist or social worker with a master's degree in social work, who is in charge of the patient \_\_\_\_\_ hereby approves/disapproves the release of information and records to the patient or personal representative specified herein.

(NOTE: If disclosure is disapproved, give reasons below and note any restrictions to the release of record. No approval is required for release to patient's attorney, unless the request is for the use or disclosure of information given in confidence by the patient's family.)

Signature: \_\_\_\_\_ Degree: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(physician, psychologist, social worker)

Date: \_\_\_\_\_

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



ROI

Patient Identification: