

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.

A. You would like access to the health information about you maintained by St. Joseph's Medical Center as follows: (check one).

- ☐ inspect only
- ☐ copy only (Fees may apply. Price list will be given upon request.)
  - ☐ Paper
  - ☐ CD
- ☐ inspect and copy (Fees may apply. Price list will be given upon request.)

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

- ☐ written summary of health information (Fees may apply. Price list will be given upon request.)

C. Tell us which type of health information you want to access (Not applicable for online patient center) (Check all that apply)

- |                                                        |                                                 |
|--------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Complete Health Record(s)     | <input type="checkbox"/> Emergency Room Records |
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Progress Notes         |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Laboratory Tests       |
| <input type="checkbox"/> Consultation Reports          | <input type="checkbox"/> X-ray reports          |
| <input type="checkbox"/> Others (please specify) _____ |                                                 |

**PLEASE FAX FORM TO: (209) 461-6882**



1800 North California Street  
Stockton, CA 95204  
(209) 943-2000



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

D. You would like access to the on-line Patient Center/Patient Portal. Email address:

- ☐ please setup account and provide instructions regarding access to Patient Portal

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. **Note that your records may include information concerning your HIV status even if you do not initial this line.)**

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 St. Joseph's Medical Center 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.



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8700-045 (Rev 08/01/2014)

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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

**HIM DEPARTMENT ONLY:**

ROI # \_\_\_\_\_ Account #: \_\_\_\_\_ Clerk: \_\_\_\_\_

Completed: ☐ Yes ☐ No By: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Request Initial Call for Invoice: ☐ Yes ☐ No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

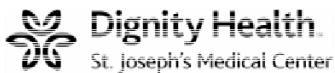
Bill to: \_\_\_\_\_ Ship to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



St. Joseph's Medical Center

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8700-045 (Rev 036/28/2014)