Date:_____ Medical record #:_____

Patient name:_____ AKA / other names:_____

Date of birth:_____ Telephone:_____

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.

1. You would like access to the health information about you maintained by Bakersfield Memorial Hospital as follows (check one):
   a. ☐ Inspect only
   b. ☐ Copy only (*Fees may apply.)*
   c. ☐ Inspect and copy (*Fees may apply.*)

2. Tell us which type of health information you want to access (check all that apply):
   a. ☐ Emergency Department Records
   b. ☐ Discharge Summary
   c. ☐ History and Physical (H&P)
   d. ☐ Consultation Reports
   e. ☐ Operative Reports
   f. ☐ Laboratory Tests
   g. ☐ X-ray Reports
   h. ☐ X-Ray Films
   i. ☐ Billing Records
   j. ☐ Complete Health Record(s)
   k. ☐ Other (please specify):_____

Bakersfield Memorial Hospital
A Dignity Health Member

420 34th Street, Bakersfield, CA 93301
661.327.4647 ext.1928

PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

3. 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:

   a. _____ Initial — HIV (Human Immunodeficiency Virus) test results (To be released upon approval of your physician.)

   b. _____ Initial — Psychiatric care (To be released upon caregiver's approval.)

   c. _____ Initial — Treatment for alcohol and/or drug abuse

4. 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 record(s) requested.

5. This request for access will not require Bakersfield 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	Time a.m. / p.m.
Print Name (if other than patient)	Telephone #	
Relationship to Patient or Personal Representative	ID Presented (attach copy)	
Address of Personal Representative (other than patient)	City	State Zip
Name of hospital employee verifying signatory information	Title and Department	

Bakersfield Memorial Hospital
A Dignity Health Member

420 34th Street, Bakersfield, CA 93301
661.327.4647 ext.1928

PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION