A Service of Dignity Health Medical Foundation
Mercy Medical Group

Release of Medical Information Department
10995 Gold Center Drive, Rancho Cordova, CA 95670
Tel. (916) 363-4040
Fax (916) 366-3662
Email: GSSA-ROI@Dignityhealth.org

PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Name of Patient:_____ Date of Birth: _____

Other Names: _____ Medical Record #: _____

Address: _____ City/State/Zip: _____

Phone Number(s): _____

- ☐ You would like your records mailed to the above address. ***OR***
- ☐ You would like to pick up your records. ***OR***
- ☐ You would like _____ (relationship: _____), to pick up your records.
- ☐ Email Address:_____
- ☐ Flash Drive:_____
- ☐ Fax: _____ (Must be a secure line)

You have requested access to health information about you from Mercy Medical Group. 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 manner in which you access your information may determine the amount of such fees.

A. You would like to access the health information about you maintained by Mercy Medical Group as follows (check one):
   - ☐ Copy only (*fees will apply*).
   - ☐ Inspect and copy (*fees may apply*).
   - ☐ Inspect only.

B. You may obtain the following in lieu of a copy of the medical records:
   - ☐ Written summary of health information (*fees will apply*).

C. Tell us which type of health information you want to access (check all that apply):
   Date(s) of Treatment: _____
   Type of Treatment: _____
   - ☐ Clinic Notes
   - ☐ Consultations
   - ☐ EKG results
   - ☐ Radiology Reports

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- ☐ Lab Reports
- ☐ OTHER: _____
- ☐ All health information pertaining to any medical history, physical condition, and treatment received ***EXCEPT (optional)***: _____
  _____

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**). ***Additional form is required***
Initial

_____ Psychiatric care (**to be released upon caregiver's approval**). ***Additional form is required***
Initial

All patients' (or personal representative's) request(s) for access to their health information are processed in the order received. Upon the Clinic'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 Mercy Medical Group to provide health information about you to anyone other than to your personal representative. If you request us to disclose health records or information about you to some other person or entity, we would need a signed authorization (different form) from you to enable us to transmit such information.

I have read and confirm the terms of access stated herein.

SIGNATURE: _____ DATE: _____
(Patient or personal representative)

_____ _____
Print name of personal representative *Relationship to patient*

Patient/Representative identification has been verified. _____ _____
Initials *Department*

*** PICTURE I.D. MUST BE PRESENTED ***

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