PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

(110.1.006 Exhibit A)

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 Dignity Health Mercy Medical Center, Mt. Shasta as follows: *(Check one)*.

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

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

- ☐ Written summary of health information *(Fees may apply.)*

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)
- ☐ Emergency Room Records
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Billing Records
- ☐ History and Physical
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ X-ray Reports
- ☐ Others *(please specify)* _____

(Original = HIM Department Copy / Yellow = Patient Copy)

D. ❑ **ONLINE PATIENT CENTER / PATIENT PORTAL ACCESS ONLY**

Email Address: _____

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 or developmental disability treatment records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status <u>even</u> 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 Mercy Medical Center Mt. Shasta 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
(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: _____

Billing Help Line
Dignity Health / HealthPort
(888) 488-7667
(916) 861-1102

Patient Portal Help Line
(877)621-8014
patientcenterstaff@dignityhealth.org