PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

ROI

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 **St. Elizabeth Community Hospital** as follows: *(Check one).*

- ☐ inspect only
- ☐ copy only *(Fees may apply. See attached price list.)*
  - ☐ Paper ☐ Electronic: ☐ USB Drive ☐ CD ☐ Other: _____
  - ☐ Email _____
- ☐ 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. 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)
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ Emergency Room Records
- ☐ Progress Notes
- ☐ Billing Records
- ☐ Laboratory Tests
- ☐ X-ray Reports
- ☐ Others *(please specify)* _____

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

Email Address: _____

E. Patient's Right to Direct Health Information to another person. You have the right to ask us to send your health information to a person of your choice. We need that person's name and full address. Please give that person's name and full address here:

_____
Print Person's First Last Name

_____
Print Address

_____
Print City, State, Zip Code

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 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.

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
Patient Directed Right of Access – Pick up Signature	Date

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: _____

Patient Identification / Label

Dignity Health.
St. Elizabeth Community Hospital

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