Dignity Health.
Glendale Memorial Hospital
and Health Center

EXHIBIT A
PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Date: _____ M.R. #or Account#: _____

Patient Name: _____ AKA/Other Names: _____

Date of Birth: _____ Phone: _____

Address: _____ City/State/Zip: _____

Covering the period of health care 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 Glendale Memorial Hospital as follows *(Check one).*
- ☐ inspect only
- ☐ copy only *(Fees may apply. See attached price list.)*
- ☐ 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 (Check all that apply):

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

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.)**
Initial

_____ Psychiatric care ***(To be released upon caregiver's approval. See page 2)***
Initial

_____ Treatment for alcohol and/or drug abuse
Initial

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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 Glendale 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
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

The undersigned, the physician, licensed psychologist or social worker with a master's degree in social work, who is in charge of the patient_____ hereby ☐ approves ☐ disapproves the release of information and records to the patient or personal representative specified herein.

(NOTE: If disclosure is disapproved, give reasons below and note any restrictions to the release of records. No approval is required for release to patient's attorney, unless the request is for the use or disclosure of information given in confidence by the patient's family.)

Signature: _____ Degree: _____

Print Name: _____ Telephone:_____
(physician, psychologist, social worker)

Date: _____

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