Dignity Health

PATIENT'S REQUEST FOR ACCESS TO BILLING RECORDS

Date: ____________________ M.R. # or Account if known: ____________________________

Patient Name: _________________________ AKA/ other names: _______________________

Date of Birth: _________________________ Phone: _________________________________

Address: _____________________________City/State/Zip_____________________________

Hospital/Facility Name: ____
(Required)

Covering the period of healthcare from *(date)* _______________ to (*date*) _________________

You have requested access to billing-related health information about you. To enable us to process your request for a billing statement, please read the following carefully and complete the requested information below.

Select documents being requested:

☐ Itemized Statement ☐ Other________________________________

Select your preference for receiving these documents:

☐ Mailed to address on statement

☐ Send Secure Email to: ____

☐ Send Non-Secure Email to: ____

NOTE: We encourage you to use secure email because it better protects your privacy, but we will send to your (non-secure) email address if you tell us to do so.

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Patient's Right to Direct Billing Statement to Another Person. You have the right to ask us to send your billing statement to a person of your choice. If you want us to send your records to someone else, please give that person's name and full address here:

____

Print Person's First Last Name

Address: ______________________________City/State/Zip______________________________

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 records
__________ Substance abuse treatment information
__________ HIV related information and other communicable diseases
__________ Genetic testing information

This request will be processed in the order received.

____ ______________________________

Patient or Personal Representative's Signature Date

____ ______________________________

Print Name Telephone #

____ ______________________________

Relationship to Patient of Personal Representative Evidence of authority (Power of Attorney Document, etc.)

Return this document to the Health Information dept directly or by mail to:
Dignity Health – Greater Sacramento Service Area
ATTN: Health Information Management/Medical Records
3400 Data Drive
Rancho Cordova, CA 95670
Phone: (916) 854-2000