

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



Patient Identification / Label

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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 even 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.



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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: _____



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