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)* _____ 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. Identify how you would like to access the health information:
- ❑ Inspect only
- ❑ Copy only (Fees may apply)
  - ❑ Paper
  - ❑ Electronic: ❑ USB Drive ❑ CD ❑ Other: _____
  - ❑ Secure Email: _____ ❑ Unsecured Email: _____
    *** If requesting unsecured email, I understand that using unsecured email may place my PHI at risk, and accept the risk of sending my PHI via an unsecured mechanism.**
- ❑ Inspect and copy *(Fees may apply)*

B. 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
- ❑ Others *(please specify)* _____
- ❑ Progress Notes
- ❑ Laboratory Tests
- ❑ Radiology Reports

Dignity Health
St. Joseph's Medical Center

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Stockton, CA 95204
(209) 943-2000

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PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

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C. **ONLINE PATIENT CENTER/PATIENT PORTAL ONLY**
Email Address: _____

D. **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 and 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 (The 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. If your request is accepted 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

HIM DEPARTMENT ONLY:

ROI # _____ Account #:_____ Clerk: _____

Completed: ☐ Yes ☐ No By: _____ Date: _____

Patient Request Initial Call for Invoice: ☐ Yes ☐ No

Comments: _____

_____

_____

Bill to: _____ Ship to: _____

_____ _____

_____ _____

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