ANAHEIM REGIONAL MEDICAL CENTER
1111 W. LA PALMA AVENUE
ANAHEIM, CA 92801
714.999.6126 TELEPHONE / 714.999.6165 FACSIMILE

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) _____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 Anaheim Regional Medical Center as follows *(Check one).*

_____inspect only
_____copy only *(Fees may apply)*
_____ inspect and copy *(Fees may apply)*

B. Tell us which type of health information you want to access *(Check all that applies):*

Complete Health Record(s)
Discharge Summary
History and Physical
Consultation Reports
Billing Records
Emergency Room Records
Progress Notes
Laboratory Tests
X-ray Reports
Other *(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.

____Mental health or developmental disability treatment records (excludes "psychotherapy notes") – **To be released upon caregiver's approval. See page 3.**

____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.

This request for access will not require Anaheim Regional Medical Center 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

**********Facility Use Only **********

[ ] Approved
[ ] Approved subject to the following restrictions
[ ] Denied (Note: Access may only be restricted or denied if you believe that providing access is reasonably likely to endanger the life or physical safety of the patient)

Restrictions:

_____

_____

_____

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: _____