



REQUEST FOR PATIENT ACCESS TO PROTECTED HEALTH INFORMATION

Eden San Leandro

I hereby request access to protected health information for:

Patient Name
Address

Phone Number(s)

Birth date Medical Record/Account No.

Information Requested.

Date(s) of service:

I would like access to the information described below (check all that apply):

Table with 3 columns: History And Physical Exam, Pathology Reports, Discharge Summary, Laboratory Tests Results/Reports, Consultation Reports, Progress Notes, Emergency Room Record, X-Ray Films/ Reports/Digital Images, Operative Report, Drugs/Alcohol, Mental Health Records, HIV Results, Other:

OR:

Entire Record: (includes everything in the medical record from your first visit until your most recent discharge, unless specific dates of service are specified).

Fees. There may be a charge for films or records.

I agree to pay the fees allowed by law for providing access to my records in advance of receipt. Fees for copies of medical records are .25 cents per page, first 8 pages are free.

Receipt.

- I will pick up the copies. Please call me at when they are ready.
I authorize to pick up the copies. Please call him/her at when they are ready.
Please mail the copies to the address indicated below.

Signed: Print Name Date:

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient Beneficiary or representative of deceased patient
Guardian or conservator of an incompetent patient Advanced Healthcare Directive

Identification Verified by:

Verified by Photo ID Matching Signature Other