Eden Medical Center
A Sutter Health Affiliate

Eden Campus: 20103 Lake Chabot Road Castro Valley CA 94546
San Leandro Hospital Campus: 13855 East 14th Street, San Leandro CA 94578

REQUEST FOR PATIENT ACCESS TO PROTECTED HEALTH INFORMATION
Eden Campus

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:

Pertinent Information: ***(includes dictated physician reports from ER or Inpatient stay and labs, radiology for dates specified)***	Entire Record: (includes everything in the medical record from your first visit until your most recent discharge, unless specific dates of service are specified). **Cost for average 3 day stay can be $100+**

OR

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:		

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

Fees for copies of medical records are 25 cents per page. You will receive an invoice from Healthport Copy Service. Record copies and invoice will be sent by mail or PDF file (Please make selection below). **If you do not retrieve records within 30 days, they will be deleted.**

Receipt.

[ ] Please provide my records as a **electronic PDF file**. My **E-mail address** is.______________________You will receive notification via e-mail when records are ready to be viewed. **(Eden campus only)**

[ ] Please **mail** the copies to the address indicated below.

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Signed: ______________________ **Print Name**______________________ **Date:** ______________

If not signed by the patient, please indicate relationship:
[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of an incompetent patient
[ ] Beneficiary or representative of deceased patient
[ ] Advanced Healthcare Directive

Identification Verified by: ____
Verified by Photo ID Matching Signature Other ______________________