

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

| | | | | |
|----------------|-------|------|-------------------------|------------------|
| Last Name | First | MI | Date of Birth (Mo/D/Yr) | Medical Record # |
| Street Address | | City | State | Zip Code |

REQUEST TO ACCESS AND INSPECT MY PROTECTED HEALTH INFORMATION ONSITE

| | | | | |
|---|---|------|-------|----------|
| <input type="checkbox"/> LAC+USC Medical Center | <input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center | | | |
| <input type="checkbox"/> Olive View Medical Center | <input type="checkbox"/> High Desert Multi-Service Ambulatory Care Center | | | |
| <input type="checkbox"/> Harbor-UCLA Medical Center | <input type="checkbox"/> Martin Luther King, Jr. Multi-Service Ambulatory Care Center | | | |
| <input type="checkbox"/> CHC/Health Center: _____ | | | | |
| <input type="checkbox"/> Other: _____ | | | | |
| Facility Name | Street Address | City | State | Zip Code |

REQUEST THE FACILITY ABOVE SEND A COPY OF MY REQUESTED PROTECTED HEALTH INFORMATION TO:

| | |
|----------------|----------------------------------|
| Name | Phone Number (include area code) |
| Street Address | City State Zip Code |

INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:

INSPECTION PERIOD: I request information during the following time period:

FROM ____ / ____ / ____ **TO** ____ / ____ / ____
Month Day Year Month Day Year

REQUEST SUMMARY OF REQUESTED PROTECTED HEALTH INFORMATION (if available)

Copy fees: DHS may charge you a reasonable fee for making copies of your protected health information at a charge of 25 cents per page for paper or fax copies; 50 cents per page for copies from microfilm.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:

Right to Receive a Copy of This Request - I understand that I am entitled to a signed copy of the form if I submit this form in person.

MRUN

NAME

DOB/GENDER



T-HS1016

Right to Request Review of Denial of Access- I understand that DHS may deny my request to access my protected health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a **Request for Review of Denial of Access to Protected health information**. In most circumstances, DHS will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

SIGNATURE OF PATIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

If signed by other than patient, state relationship and authority to do so:

DATE: ____ / ____ / ____
Month Day Year

FOR OFFICE USE ONLY

Form(s) Of Identification Provided:

- State Driver's License _____
- Birth Certificate _____
- Other (Provide details) _____
- State Identification Card _____
- Military ID _____

Facility: _____

Processed by: _____ Title: _____ Date: _____
Employee Name

For more information about your health privacy rights, ask the facility staff member for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at <http://www.dhs.co.la.ca.us/>.

MRUN

NAME

DOB/GENDER

