DOCTORS MEDICAL CENTER

ATTACHMENT A
DOCTORS MEDICAL CENTER
ACCESS REQUEST FORM

Patient's Name:			
	Last	First	Middle
Home Address:			
Home Phone:			
Date of Birth:			
Date of Request:			

I hereby request that DOCTORS MEDICAL CENTER provide me with [please check all boxes that apply]

- ❒ Access to OR
- ❒ My own copy of the "Requested Information" checked below:
  - ❒ My medical records
  - ❒ My billing records
  - ❒ Any other records containing personally identifiable information and used by DOCTORS MEDICAL CENTER to make medical or billing decisions about me.

[Please also check one of the three boxes below:]

- ❒I am only interested in accessing or obtaining a copy of the Requested Information relating to the time period _____ through _____ .
- ❒ I am interested in accessing or obtaining a copy of all Requested Information maintained by DOCTORS MEDICAL CENTER.
- ❒ I would prefer to receive the Requested Information in the form of a summary prepared by DOCTORS MEDICAL CENTER at a cost of 25 cents per page.

I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or for use in) a civic, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law.

If I am a parent or legal guardian requesting Access to a minor's information, I further understand that I will not be provided access to records related to certain categories or treatment as required by law (for example, records pertaining to health care services for which the minor can lawfully given consent and therefore for which the minor has the right to inspect or obtain copies of the record (i.e., abortion or mental health treatment); or the health care provider determines, in good faith, that access to the Patient records requested by the representative would have a detrimental effect on the provider's profesional relationship with the minor Patient or on the minor's physical safety of psychological well being.

I understand that DOCTORS MEDICAL CENTER may deny this request under limited circumstances as provided for under Federal and State law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed

health care practitioner selected by the DOCTORS MEDICAL CENTER who did not participate in the DOCTORS MEDICAL CENTER's decisión to deny my request.

I understand that DOCTORS MEDICAL CENTER will notify me of its decisión to approve or deny my request to access within five (5) working days or obtain a copy of the Requested information within fifteen (15) days of receiving this request.

I understand that if a summary is requested, I will be able to inspect or obtain a copy of the summary within ten (10) working days from the date of my request. If DOCTORS MEDICAL CENTER needs additional time to prepare the summary because the record is of extraordinary length or because the Patient was discharged from a licensed health facility within ten (10) days prior to the request, I will be so notified and DOCTORS MEDICAL CENTER may have up to thirty (30) days from the date of my request to make the summary available to me.

Please provide the Requested Information to me in [please check the appropriate box]:

❒ electronic form (on a disc) OR
❒ paper form

I would prefer to:

❒ pick-up or view the Requested Information at a mutually agreeable time and place; OR
❒ have the Requested Information mailed to me at the following address:

_____
_____
_____

I understand that DOCTORS MEDICAL CENTER will charge me 25 cents per page for the copying serrvice necessary to complete my request, as welll as applicable mailing fees. If I am granted access to the Requested Information, I [please check the appropriate box]:

❒ would; OR
❒ would not like DOCTORS MEDICAL CENTER to provide me with an additional written explanation of such Request Information at an additional cost to me of 25 cents.

_____ _____
Signature of Patient (or Personal Representative) Date

_____ _____
Printed name of Personal Representative Date

_____
Relationship of Personal Representative to Patient

* * * * *

After you have completed this form, please return it to the Medical Records Department by mail or by facsímile at the following address: Medical Records Department; DOCTORS MEDICAL CENTER , 2000 Vale Road, ,CA 94806, (Fax: (510) 970-5740.

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as driver's license or Passport, or comparison of signatures documented in the PHI records

_____
Signature of the employee validating identify