

<input type="checkbox"/> ID Verified <hr style="width: 50%; margin: 0 auto;"/> Staff Initials
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MR#: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 IMPRINT AREA

**REQUEST FOR ACCESS TO OR COPIES OF MEDICAL RECORDS**  
*(This is not to be used as a HIPAA Authorization)*

1. This request is made pursuant to California Statute, Health and Safety Code sections 123100-123149. Under these sections I understand that the health care provider (hospital or medical group) is entitled to "payment of reasonable clerical costs incurred in locating and making the records available" before access to the records is permitted. If copies are requested, I acknowledge that the law requires me to pay reasonable clerical costs and permits copying fees of 25¢ cents per page after 5 pages, plus postage for mailing copies.
2. I understand that the provider has 5 working days, **after receiving this request**, in which to produce the requested medical records for examination. If I have requested copies, the provider has 15 calendar days, **after receiving this request**, during which to assemble the records and make copies in the requested format.
3. I understand that records of mental health care or alcohol or drug abuse treatment may not be disclosed to me directly if the health care provider determines that to do so would present a risk of significant adverse or detrimental consequences. I understand that the provider may provide me with a summary of the requested records instead of copying or providing the original records for examination. I understand I then may designate a physician, licensed psychologist, or clinical social worker to review the record on my behalf.
4. I understand that if I am a parent making a request regarding records of a minor, I will not be shown entries for health care to which, by law, the minor may consent with out parental involvement.
5. I understand that if I am a minor, I will be given access only to those portions of my record describing health care for which I may consent, under applicable law, without involvement of parents.
6. The undersigned patient or patient's legal representative hereby requests access to the Medical Records of:  
 \_\_\_\_\_  Adult  Minor

*(Patient Name)*

7. Medical Center/Facility locations for which I am requesting records: \_\_\_\_\_
8. I am requesting:
 

<input type="checkbox"/> Access to the record above (no fee)	<input type="checkbox"/> Paper copies made of the record indicated
<input type="checkbox"/> Pick up	<input type="checkbox"/> Mail (postage fees charged)
<input type="checkbox"/> CD	<input type="checkbox"/> Fax up to 10 pages to this number ( _____ )
<input type="checkbox"/> _____	<input type="checkbox"/> Electronic release
9. For the purpose of: \_\_\_\_\_
10. Check the box(es) to specify which type of information is being requested:  
 Medical     Mental Health     Drug/Alcohol     HIV test results  
 For the period \_\_\_\_\_ to \_\_\_\_\_

**The record information being requested is: (check all that apply)**

**Physician Office Records Requested**

- |  |   |
|--|---|
| <input type="checkbox"/> Immunizations                                     | <input type="checkbox"/> Phone Messages         |
| <input type="checkbox"/> Lab/Pathology                                     | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Medications                                       | <input type="checkbox"/> Prenatal               |
| <input type="checkbox"/> Obstetrics/Gyn                                    | <input type="checkbox"/> Radiology Reports      |
| <input type="checkbox"/> Occ Medicine                                      | <input type="checkbox"/> Radiology Images/Films |
| <input type="checkbox"/> Test Results (EMG, EKG, EEG, Sleep, Stress, Bone) |   |
| <input type="checkbox"/> Office Visits                                     |   |
| <input type="checkbox"/> Ophthalmology                                     |   |

**Hospital Unit Records Requested**

- |  |  |
|--|--|
| <input type="checkbox"/> Consultation-Typed                          | <input type="checkbox"/> Orders                  |
| <input type="checkbox"/> Discharge Summary                           | <input type="checkbox"/> Progress Notes          |
| <input type="checkbox"/> Emergency                                   | <input type="checkbox"/> Physical Therapy Notes  |
| <input type="checkbox"/> EKG – Tracings                              | <input type="checkbox"/> Radiology Films         |
| <input type="checkbox"/> History and Physical                        | <input type="checkbox"/> Radiology Images        |
| <input type="checkbox"/> Lab/Pathology                               | <input type="checkbox"/> Surgery Info Operative, |
| <input type="checkbox"/> Medications                                 |  |
| <input type="checkbox"/> Notes (All, i.e., Doctor, Nurse, Procedure) |  |

\_\_\_\_\_ Initial Ok to leave message: \_\_\_\_\_ (Ph #)    Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient Representative Signature: \_\_\_\_\_    Patient Address: \_\_\_\_\_  
 Date: \_\_\_\_\_ Relationship: \_\_\_\_\_    City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_