COUNTY OF TUOLUMNE

REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION

You have the right to request to review your personal health information we create or maintain. You also have the right to request copies of those records for which you will be charged $.25 per page. Within fourteen (14) business days after we receive your request to access your record, one of our staff will contact you to set an appointment for you to review your records or we will inform you in writing that we have denied your request for access and state the reason why. After you have completed this form, you need to mail or return it to:

INSERT YOUR DEPARTMENT ADDRESS HERE:

DATE:

PATIENT/RESIDENT/CLIENT			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	AKA'S:	SSN:	DATE OF BIRTH:

REPRESENTATIVE INFORMATION		
I am the legal representative of the above patient/resident/client and hereby request to receive his/her personal health information.		
LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
RELATIONSHIP:		TELEPHONE NUMBER:
REASON FOR REQUEST:		

PERSONAL HEALTH INFORMATION TO WHICH YOU WANT ACCESS	
☐ History and Physical Examination	☐ Physician Orders
☐ Discharge Summary	☐ Pharmacy records
☐ Progress Notes	☐ Immunization Records
☐ Medication Records	☐ Nursing Notes
☐ Interpretation of images: x-rays, sonograms, etc.	☐ Billing records
☐ Laboratory results	☐ Drug/Alcohol Rehabilitation Records
☐ Dental records	☐ Complete Record
☐ Psychiatric records including Consultations	☐ Other *(Provide description)*

From what dates do you want information *(period of time)*

Date to begin search:	Date to end search:

ACCESS METHOD AND LOCATION	
Where and when do you want to inspect or receive copies of your information:	
IN PERSON: ☐ YES	LOCATION:
COPIES BY MAIL: ☐ YES	

YOUR SIGNATURE	
SIGNATURE:	DATE:

FOR OFFICE USE

VALIDATE IDENTIFICATION ☐	
SIGNATURE OF STAFF PERSON:	DATE: