Request for Patient Access to Health Information

Perinatal Associates of Central California Medical Group, Inc
2210 E Illinois Ave Ste 308, Fresno, CA 93701-2184
2273 E Beechwood Ave, Fresno, CA 93720-0329
Privacy Officer 559-268-8307

As required by the Health Information Portability and Accountability Act of 1996 and California law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

I hereby request access to health information for:

_____

_____

(Print Patient's name and address)

If known: Date of birth: _____

SCOPE OF ACCESS REQUESTED

I would like access to: ☐ All the records ***or***
☐ The portion of the records concerning:

_____

_____

_____

_____

(Specify type of disease, accident, dates of treatment, or other portion of records you are interested in.)

TYPE OF ACCESS REQUESTED

☐ Inspection. Please let me know when I may come to inspect the records. I understand that an employee of this medical practice may be present and that I may not make any marks or alter the records in any way.

☐ Copies. I would like copies of ☐ All records requested ***or***
☐ All records other than X-rays or tracings

☐ Transfer. Please transfer ☐ Copies of all records requested ***or***
☐ Original X-rays or tracings only

To: _____

(Name and address of health care provider to whom the records are to be delivered)

☐ I would like the information in the following form or format if it is readily produceable in this form:

_____.

CHARGES

Copies or Transfer. I understand that you may charge me a reasonable charge of up to twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for copies from microfilm. I further understand that you may charge me your actual costs for copies of any X-rays or tracings derived from electrocardiography (E.K.G.), electroencephalography (E.E.G.) or electromyography (E.M.G.).

☐ I hereby agree to pay the charges specified above. Please bill me.

☐ Please call me to let me know how much these copies will cost.

☐ I am requesting these records be provided without charge to appeal the denial of eligibility for Medi-Cal, SSDI or SSI/SSP benefits. A copy of the program's denial notice is attached. I applied for these benefits on _____ (date).

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient