Huntington Health Physicians

MEDICAL RECORDS REQUEST

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:

Patient's name_____

Date of birth:_____

Address _____

_____

SCOPE OF ACCESS REQUESTED

I would like access to:

☐ All the records concerning: 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, and the amount of the charge, if any. I understand that an employee of this medical practice will be present and that I may not make any marks or alter the records in any way.

☐ Copies:
  ☐ **Dermatology Records**

☐ Transfer. Please transfer
  ☐ **Dermatology Records**

_____
Physician Name

_____
Address

_____
City State Zip

_____ _____
Fax Number Phone Number

CHARGES

Inspection: I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of $6.00 per quarter hour and I will be required to pay these costs before I may inspect the records.

Copies or Transfer: I understand that you will charge me twenty-five cents (25¢) per page, or fifty cents (50¢) per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available. I further understand that you may charge me your actual costs for copies of any X-rays or tracings derived from electrocardiography (EKG.), electroencephalography (EEG.) or electromyography (EMG.).

☐ I hereby agree to pay the charges specified above upon inspection or prior to receipt of copies.

☐ 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 ___/___/___.

Signed: _____

Print Name: _____

Date:___/___/___ 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

Name of Patient: _____