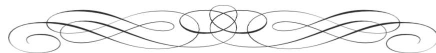

Request for Patient Access to Health Information

Barbi Phelps-Sandall, M.D., F.A.C.O.G., M.Ed.
2495 Hospital Drive, Suite 515
Mountain View, CA 94040
Phone 650-988-7830 Fax 650-966-9207

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

☐ 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 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

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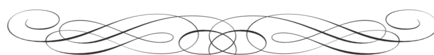

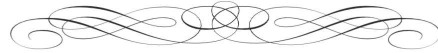

Health Care Provider to whom the records are to be delivered:

Name: ____

Address: ____

____

____

Charges
I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of $50.00 and I am required to pay these costs before I may inspect the records.

Copies or Transfer
I understand that I will be charged $50.00 per copy of records.

☐ I hereby agree to pay the charges specified

☐ 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) _____/______/______

Print Name:__________________________________ **Date**:______/________/________

Signature:____________________________________ **Phone Number**: _______________

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