REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

Last Name | First | MI | Date of Birth (Mo/D/Yr) | Medical Record #

Street Address | City | State | Zip Code

☐ **REQUEST TO ACCESS AND INSPECT MY PROTECTED HEALTH INFORMATION ONSITE**

☐ Los Angeles General Medical Center	☐ Rancho Los Amigos National Rehabilitation Center
☐ Olive View Medical Center	☐ High Desert Multi-Service Ambulatory Care Center
☐ Harbor-UCLA Medical Center	☐ Martin Luther King, Jr. Multi-Service Ambulatory Care Center
☐ CHC/Health Center: _____	
☐ Other: _____ Facility Name Street Address City State Zip Code	

☐ **REQUEST THE FACILITY ABOVE SEND A COPY OF MY REQUESTED PROTECTED HEALTH INFORMATION TO:**

Name | Phone Number (include area code)

Street Address | City | State | Zip Code

INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:

INSPECTION PERIOD: I request information during the following time period:

FROM _____ / _____ / _____ **TO** _____ / _____ / _____
Month Day Year Month Day Year

☐ **REQUEST SUMMARY OF REQUESTED PROTECTED HEALTH INFORMATION** (if available)

Copy fees: DHS may charge you a reasonable fee for making copies of your protected health information at a charge of 25 cents per page for paper or fax copies; 50 cents per page for copies from microfilm.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:
Right to Receive a Copy of This Request - I understand that I am entitled to a signed copy of the form if I submit this form in person.

MRUN

NAME

DOB/GENDER

Right to Request Review of Denial of Access- I understand that DHS may deny my request to access my protected health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a ***Request for Review of Denial of Access to Protected health information***. In most circumstances, DHS will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

SIGNATURE OF PATIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

If signed by other than patient, state relationship and authority to do so:

_____

DATE: _____ / _____ / _____
Month Day Year

FOR OFFICE USE ONLY

Form(s) Of Identification Provided:

☐ State Driver's License _____ ☐ State Identification Card _____
☐ Birth Certificate _____ ☐ Military ID _____
☐ Other (Provide details) _____

Facility: _____

Processed by: _____ Title: _____ Date: _____
Employee Name

For more information about your health privacy rights, ask the facility staff member for a copy of our ***Notice of Privacy Practices***. You may also obtain a copy by visiting our website at http://www.dhs.co.la.ca.us/.

MRUN

NAME

DOB/GENDER