Request for Access to Protected Health Information – Office of Diversion and Reentry

Health Services
LOS ANGELES COUNTY

Submit this form to odr.inquiries@dhs.lacounty.gov

This form is for Office of Diversion and Reentry patients/clients to view their own medical records in person, and if applicable, to authorize release of information to specific parties.

PATIENT/CLIENT INFORMATION (Type or print)			
Last Name:	**First Name:**		
Date of Birth:	**Last 4 digits of Social Security Number (If Applicable):**		
Phone Number:	**Alternate Contact Phone Number:**		
Street Address:	**City:**	**State:**	**Zip Code:**

RELEASE INFORMATION FROM:

☐ Office of Diversion and Reentry
☐ Los Angeles General Medical Center
☐ Harbor-UCLA Medical Center
☐ Olive View Medical Center
☐ Rancho Los Amigos National Rehabilitation Center
☐ Martin Luther King Jr. Outpatient Center
☐ Correctional Health Services
☐ All DHS facilities

ODR or Facility	City	State	Zip Code

REQUEST OFFICE OF DIVERSION AND REENTRY/THE FACILITY ABOVE SEND A COPY OF REQUESTED PROTECTED HEALTH INFORMATION TO:			
Name:	**Phone Number and E-mail:**		
Street Address:	**City:**	**State:**	**Zip Code:**

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INFORMATION TO BE ACCESSED, COPIES OR INSPECTED:

_____

_____

_____

I REQUEST INFO FROM THE FOLLOWING PERIOD (Month, Day, Year): FROM _____ TO _____

YOUR RIGHTS REGARDING THIS REQUEST:

Right to Receive a Copy of This Request: I understand that I am entitled to a signed copy of the form.

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 the 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: _____ DATE _____ ***or***

SIGNATURE OF PERSONAL REPRESENTATIVE: _____ DATE _____

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

_____

Health Privacy Rights: For more information about your health privacy rights, ask the staff member for a copy of our Notice of Privacy Practices.

FOR OFFICE USE ONLY

Form(s) of Identified Provided:

☐ Driver's License _____ ☐ ID card _____
☐ Birth Certificate _____ ☐ Military ID _____
☐ Other (Provide Details): _____

FACILITY: _____

PROCESSED BY: _____ TITLE _____