CLIENT'S REQUEST FOR ACCESS/INSPECTION TO HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client	Date of Birth of Client	Client ID #

Street Address	City, State, Zip

☐ **REQUEST TO ACCESS AND INSPECT MY HEALTH INFORMATION, "ON SITE"**

☐ **REQUEST TO EMAIL MY HEALTH INFORMATION**

☐ **REQUEST TO MAIL MY HEALTH INFORMATION**

☐ **REQUEST TO PICK-UP HARD COPIES**

AT:

INFORMATION TO BE ACCESSED OR INSPECTED:

☐ Assessment/Evaluation	☐ Psychological Test Results	☐ Diagnosis
☐ Laboratory Results	☐ Medication	☐ Treatment/Progress Notes
☐ Entire Record		
☐ Other (Specify): _____		

☐ Requesting All Programs of Service

☐ Requesting a Specific Program of Service

(Specify)_____

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

FROM ____/____/____ **TO** ____/____/____

Month Day Year Month Day Year

☐ **REQUEST SUMMARY OF REQUESTED HEALTH INFORMATION**

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YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:

Right to Receive a Copy of This Request - I understand that I must be provided with a signed copy of the form.

Right to Request Review of Denial of Access- I understand that DMH may deny my request to access my 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***. In most circumstances, DMH 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 CLIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE:

_____

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

_____

DATE: _____/_____/_____

Month Day Year

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FORM(S) OF IDENTIFICATION PROVIDED:

☐ State Driver's License _____

☐ State Identification Card _____

☐ Birth Certificate _____

☐ Military ID _____

☐ Other (Provide details) _____

FACILITY: _____

PRACTITIONER: _____ **DATE:** _____/_____/_____

Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at https://dmh.lacounty.gov/our-services/consumer-and-family-affairs/privacy or by sending a written request to:

Office of Patient's Rights
Los Angeles County Department of Mental Health
510 S. Vermont Ave., 21st Floor
Los Angeles, CA 90020

Phone: (800) 700-9996 Fax: (213) 330-0285

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.