Request for Patient Access to Health Information

INTERNAL MEDICINE ASSOCIATES OF SAN MATEO

100 S. ELLSWORTH AVE., SUITE 700, SAN MATEO, 94401

Tel No. (650) 347-0063 Fax No. (650) 347-6829

As required by the Health Information Portability and Accountability Act of 1996 and California law, you have a right to request a copy of the 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 anticipation 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: ____

Address: ____

Date of Birth: ________________________

REASON FOR REQUEST: ( ) Transfer of Care ( ) Personal Copy

SCOPE OF HEALTH INFORMATION REQUESTED

I would like access to: All the records ( ) ***or***

The portion of the records concerning ( )

(Specify type of disease, accident, dates of treatment, or other portion of records you are interested in.)

Transfer ( ) To ( ) From:

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(Name and address of health care provider)

Tel No: ________________________ **Fax No:** ________________________

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CHARGES

Personal Copy: Fee of $25.00 applies. For charts less than 20 pages, a fee of $15.00 applies

Transfer to a New Doctor: Courtesy

Electronic Health Records: I understand that if I asked for a copy of my electronic health record you will only charge me for the actual labor costs incurred in responding to a request for electronic health records, summaries or explanations.

- I hereby agree to pay the charges specified above ( )
- Check enclosed. Check No. _________ ( )
- Credit Number: ____ Exp. Date: _______________

  Type of Credit Card: Mastercard ( ) Visa ( )

Signed: ____________________________ **Date:** ___________________________________

Print Name: _______________________ **Telephone:** ______________________________

<u>If not signed by the patient, please indicate relationship:</u>

- parent or guardian of patient ( )
- guardian or conservator of an incompetent patient ( )
- beneficiary or personal representative of deceased patient ( )
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NOTE: THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.