Request for Access to Patient's Health Information

As a patient of FREMONT HOSPITAL, you are entitled under federal law and California State law to have access to personal protected health information. For mental health and/or drug/alcohol abuse records the law requires the physician's written approval prior to access.

In order to process your request for access to this information, please complete this form and submit it to the Director of Health Information Management. When received by the Director of Health Information Management, he or she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Director of Health Information Management at (510) 574-4812.

Patient Information:

Patient Name: _____ Birth Date: _____

Patient Number: _____ Date of Access Request: _____

Patient Phone Number: _____

Access Method and Information Requested

You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both. If you select "copy," please indicate your method of delivery.

[ ] I would like to **view** my protected health information. I have/will schedule(d) an appointment with FREMONT HOSPITAL to view my health information on _____. I understand FREMONT HOSPITAL may have a staff member sit down with me as I review my health information.

[ ] I would like a **copy** of my protected health information. I understand that FREMONT HOSPITAL may charge me a fee for the copies (including faxed copies) according to relevant state law.

□ I would like a copy of the entire record. The fee is $15 plus $.25 per page to copy the entire record. I understand that it is required to pay the fee in full.

□ I would like copies of the free documents only. As a customer service, FREMONT HOSPITAL provides free of charge the following items:

- Discharge Summary
- Psychiatric Evaluation
- History and Physical
- Lab Results
- Psychological Testing (if applicable)

□ A letter of participationwith dates and physician's name.

□ A letter of participation with dates, physician's name, and diagnosis.

I have selected my delivery method below:

[ ] I will return to FREMONT HOSPITAL to pick up the copy when ready.

[ ] I would like FREMONT HOSPITAL to send the copy via US mail to the following address:

_____

_____

[ ] I would like FREMONT HOSPITAL to send the copy via fax to the following number: _____.

[ ] I would like FREMONT HOSPITAL to provide to me an explanation or summary of the information provided. I understand that FREMONT HOSPITAL may charge me a fee of $150.00 for the explanation or summary, and I may be required to pay the fee in full before I can obtain the explanatory summary.

I understand that FREMONT HOSPITAL is given 15-days to process my request for access if my information is maintained on-site and that FREMONT HOSPITAL may extend the deadline by an additional 15-days if I am notified in writing of the extension. If I was discharged within the past 10-days, FREMONT HOSPITAL is given 30-days to process my request. I further understand that my rights are limited to any information in my medical record as compiled by FREMONT HOSPITAL.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

Today's Date Patient Signature

_____ ___ _____

Parent/Guardian Relationship to Patient

***Required if patient is a minor**