Child and Adolescent
Neurology Consultants

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Request for Patient Access to Health Information

○ PAUL CHRETIEN, M.D.

PRIVACY OFFICER/ ADMINISTRATOR: (916) 649-9800

As required by the Health Information Portability and Accountability Act of 1996 and California law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate you r request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extent to information compiled in reasonable participation 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:

____

____

(Print Patient's name and address)

Patient's Date of Birth: ___________________

SCOPE OF ACCESS REQUESTED

I would like access to: _____ All the Records *or*
_____ Portion of records concerning:

____

____

____

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

TYPE OF ACCESS REQUESTED

_____ Inspection, please let me know when I may come to inspect the records, and the amount of charge, if any. I understand that an employee of this medical practice may be present and that I may not make any marks or alter the records in any way.

_____ Copies, I would like copies of: _____ All records requested *or*
_____ All records other than X-rays or tracings

_____ Transfer, Please transfer: _____Copies of all records requested *or*
_____Original X-rays or tracings only

To: ____
(Name and address of health care provider to whom the records are to be delivered.)

_____ I would like the information in the following form or format if it is readily producible in this form:

____

CHARGES

Inspection: I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of [$6.00] per quarter hour and I may be required to pay these costs before I may inspect the records.

Copies or Transfer: I understand that you may charge me a reasonable charge of up to twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for copies from microfilm, plys any additional reasonable clerical costs incurred in making the records available. I further understand that you may charge me your actual costs for copies of any X-rays or tracings derived from electrocardiography (E.K.G.), ultrasound, holter or any other tracings.

______ I hereby agree to pay the charges specified above. Please bill me.

______ please call me to let me know how much these copies will cost.

______ I am requesting these records be provided without charge to appeal the denial of eligibility for Medi-Cal, SSDI, or SSI/SSP benefits. A copy of the program's denial notice is attached. I applied for these benefits on _______________*(date)*.

Signed: ________________________________ **Date:** ____________________________

Print Name: ____________________________ **Telephone:** ______________________

If not signed by the patient, please indicate:
Relationship:
______ Parent or Guardian of minor patient

______ Guardian or conservator of an incompetent patient

______ Beneficiary or personal representative of deceased patient

Name of Patient: ____