SAN JOAQUIN GENERAL HOSPITAL
500 West Hospital Road
French Camp, CA. 95231
(209) 468-6000

MEDICAL RECORD NUMBER

_____

HIPAA PRIVACY
REQUEST FOR ACCESS TO MEDICAL INFORMATION

You have the right to request a review of your personal medical or financial records we have or have made. You have the right to request copies of those records. If you choose copies, you will be charged. (See fee schedule located on the back of this form). We will allow you to see your records when you provide one form of picture identification. Another person may represent you if they are legally authorized to do so by federal or State laws or regulations. After you have completed this form, you need to mail or return it to:

Medical Records/HIM Department
San Joaquin General Hospital
PO Box 1020
Stockton, CA. 95201-1020
(209) 468-6640 fax: (209) 468-6653

DATE:

YOUR INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:

DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:	MEDICAL RECORD NUMBER:	BIRTH DATE:

PERSONAL HEALTH INFORMATION YOU WANT ACCESS TO

- ☐ Clinic visits
- ☐ Summaries of or images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Emergency Record
- ☐ Operative Reports
- ☐ History & Physical
- ☐ Pharmacy records
- ☐ Hospital stay records
- ☐ Billing records
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Other *(State what it is you want.)*

Indicate what dates do you want information *(period of time for which you want information)*

FROM:	TO:

WHERE AND WHEN

Where and when do you want to see or get copies of your information:

☐ IN PERSON	☐ BY MAIL
☐ BY E-MAIL	Enter Email/ Mailing address if different than one provided above.

YOUR SIGNATURE

SIGNATURE: Actual signature required. E-Signature not accepted.	DATE:

Representative:	Relationship:	Date:

Witness:	Date:

FOR ADMINISTRATIVE USE TO TRACK ACCESS REQUESTS

Action on Request	Date Accessed: (Must be within 15 days of Receipt of Request [45 C.F.R. § 164.524(c)(3)])

Check the box(es) below to indicate action taken on request for access to PHI.

☐ How was the identity of the individual verified?

☐ Date the individual was informed. Individual informed by: ☐ Letter ☐ Telephone

Attach copies of any correspondence to this form.

FEE SCHEDULE FOR COPIES

Charges for copies: 25 cents/page

These charges apply to all copies of medical records including x-rays, or tracings from electrocardiography, electroencephalography or electromyography.

In addition, should you require the original x-rays, contact the Radiology Department directly.

$ Cost of copying (if appropriate)

SJGH REPRESENTATIVE:	DATE: