SACRAMENTO MIDTOWN ENDOSCOPY CENTER

3941 J Street, Suite 460
Sacramento, CA 95819

PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Date:________________________________ SS#________________________________

Patient Name:__________________________ Date of Birth:________________________

Address:_______________________________ City/State/Zip:_______________________

Phone:________________________________ Date of Procedure:____________________

You have requested access to health information about yourself. To enable us to process your request, please read the following carefully and complete the requested information below.

A. You would like access to your medical record chart maintained by Sacramento Midtown Endoscopy Center as follows: (Check one).
   - ☐ inspect only
   - ☐ copy only
   - ☐ inspect and copy

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances or access may require consultation with your physician or healthcare provider responsible for your care before release. If you are requesting access to records relating to any of the following, please initial each applicable item to confirm your request.

_____HIV (Human Immunodeficiency Virus) Test Results (To be released upon approval of your physician)
Initial

_____Psychiatric care (To be released upon caregiver's approval)
Initial

_____Treatment for alcohol and/or drug abuse
Initial

This request for access will not require Sacramento Midtown Endoscopy Center to provide health information about you to anyone other than to you or your personal representative. If you request us to disclose health records or information about you to some other person, we may need a signed authorization (a different form) from you to enable us to transmit such information.

I have read and confirm the terms of access stated herein.

Patient or Personal Representative's Signature	Date
Print name if other than Patient	Telephone Number
Relationship to Patient of Personal Representative	ID Presented
Name of Facility employee verifying signatory information	Title

NOTIFICATION TO PHYSICIAN:___________________________ Your patient has requested copies of their medical record. State/Federal laws permit you to deny access in certain circumstances. Please notify us by ____________________ if you wish to deny access, otherwise we will provide copies of the record.

DATE RECORDS RELEASED/SENT:_____________PERSON RELEASING RECORDS:_______________