Request for Patient Access to Health Information

Oskie Pediatrics
P.O. Box 3464
Saratoga, CA 95070
Carol Osofsky, Privacy Officer

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 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 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)

Birth date: _____

SCOPE OF ACCESS 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.)

TYPE OF ACCESS REQUESTED

☐ Copies. I would like copies of ☐ All records requested ***or***

☐ Transfer. Please transfer ☐ Copies of all records requested
To: _____

_____

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

Signature relationship to child date

****Patient's of full legal age (18 years & up) must sign their own form, both pages- please!****

CHARGES

Copies or Transfer. I understand that the cost for the records is $25.00 per patient, plus postage. You may either mail a check to the address on this form, or you can pay via the Paypal link which has been sent to you via text.

☐ I hereby agree to pay the charges specified above.

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: _____