Request for Patient Access to Health Information

Oskie Pediatrics
555 Knowles Dr. Suite 219
Los Gatos, CA 95032
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

☐ Inspection. Please let me know when I may come to inspect the records. 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***

☐ 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

CHARGES

Copies or Transfer. I understand that you **may** charge me a reasonable charge of up to twenty-five cents ($0.25) per page, plus any additional reasonable clerical costs incurred in making the records available. I understand it is the usual policy of Oskie Pediatrics to not require payment if the records are going directly to another medical provider.

☐ 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.

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: ____