

Request for Access To Health Information

I request access to health information for:

Patient Name: _____

Address: _____

Birth Date: _____ Phone: _____

Date(s) of Service: _____

CHECK INFORMATION REQUESTED (✓):

- | | |
|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report(s) |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> EKG Report(s) |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Echocardiogram Report(s) |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Inpatient Progress Notes | <input type="checkbox"/> Same Day Surgery Record |
| <input type="checkbox"/> Outpatient Clinic Records | <input type="checkbox"/> Complete Medical Record |
| <input type="checkbox"/> Emergency Record | <input type="checkbox"/> Radiology Images (x-rays) |
| <input type="checkbox"/> Laboratory Test(s) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Radiology Report(s) | |

Form of access requested: Paper copy CD Inspection

Delivery request: Mail I will pick-up

SIGNATURE:

Date Time Signature (Patient/Representative)

If signed by other than patient, print name and relationship:

Name Relationship

Mail Completed Form To:

Mills-Peninsula Health Services
Health Information Management Department
1501 Trousdale Drive
Burlingame, CA 94010