REQUEST FOR ACCESS AND/OR COPIES OF PERSONAL INFORMATION

CONSUMER SECTION – Complete the following information:

Consumer Name (Print): _____ DOB: _____

☐ I am requesting an appointment to review my medical record and/or flag items for photocopying.

☐ I do not want a medical record review appointment, but I do request photocopies of specific medical record documents at $.10 per page. As marked below.

☐ I am requesting copies be mailed to me at the following address:

_____

☐ I am requesting encrypted electronic copies be emailed to me at: _____

Appointment Information: Contact the facility to make an appointment with Clinical Records.

INSTRUCTIONS: Upon approval you have the right to review your records within 30 days of receipt by DDS of this form, but no more than 60 days for records that are geographically dispersed, or inactive in central storage, in accordance with Civil Code Section 1798.34.

Access or copies are requested for the following specific information:	
Document:	**Date(s):**

Signature of Consumer OR ☐ Personal Representative	Date
Printed Name	

(If additional space is needed, attach a list of the requested documents)

Sections below for DDS use only

☐ **(If personal representative) Authority of the Personal Representative to sign on behalf of the Consumer has been verified. Staff initials** _____

Form Received by DDS Date/Time: _____

Record Review Appt Date/Time: _____

TREATMENT TEAM/UNIT PSYCHIATRIST/DESIGNEE – Review and respond to request within five days of receipt. The decision of the Treatment Team/Unit Psychiatrist/Designee is to be initialed below.

____FULL APPROVAL	Consumer may review and/or receive photocopies of medical record documents.
____SUMMARY	Consumer has agreed to and will be provided a verbal/written summary of the information in lieu of approving access to and/or providing copies of the actual medical record.
____*PARTIAL DENIAL	Consumer may review and/or receive selected photocopies of medical records excluding the documents as follows: _____
____*ACCESS DENIED	A licensed health care professional has determined that the access requested is reasonably likely to endanger the life or physical safety of the consumer or other individual. The reason(s) for the denial must be explained to the consumer.

Basis for Denial: _____

_____

Print Name of Designated Team Member and Title: _____

Signature: _____ **Date:** _____

*Chief Privacy Officer, or designee, review is required in the case of partial or full denial of access.

CHIEF PRIVACY OFFICER, OR DESIGNEE, DECISION:

____ CONCUR WITH DENIAL	Consumer will be provided with information on how to file a complaint to the provider or to the secretary of DHHS.
____ DISAGREE WITH DENIAL	Consumer to be provided access to medical record.

____ RECORDS REQUESTED DO NOT EXIST

Print Name of Chief Privacy Officer, or designee: _____

Signature of Chief Privacy Officer, or designee: _____ **Date:** _____

* If denied or modified access is upheld, consumer may request a “Right of Review Process” by initialing and dating here: Initial:_____ Date: _____

The information collected on this form is used to process your request for access to personal information about you maintained by DDS and shall be maintained and kept confidential pursuant to DDS’ privacy policy, which can be found at https://www.dds.ca.gov/general/privacy-policy/.