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Phone: 415-834-3000 Fax: 415-834-3099

Request for Patient Access to Health Information

Dr. Philip Chenette's Care Team at Pacific Fertility Center

55 Francisco Street, # 500 San Francisco, CA 94133

Phone: (415) 834-3684 Fax (415) 820-4148

Or scan and e-mail to ChenettesCareTeam@pacificfertility.com

(Please type or print legibly in blue or black ink)

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, the undersigned patient, or patient's legal representative, request copies of medical records for:

Patient's Name: _____

Address: _____
(Street address, including apartment or unit number)

(City, State, Zip Code)

Date of Birth: _____ Social Security Number: _____

Date(s) of Treatment requesting: _____

Daytime Phone Number: _____ Evening Phone Number: _____

SCOPE OF ACCESS REQUESTED

I would like access to:

- All the records, including results of laboratory tests for infectious disease/HIV
- The portion of the records concerning:

(Specify type of disease, accident, dates of treatment, or other portion of records in which you're interested)

CHARGES

- ❖ There is no charge when records are sent via fax or e-mail in PDF file.
- ❖ Otherwise we may charge a reasonable charge of up to twenty-five cents (\$0.25) per page, plus any additional reasonable clerical costs of copying these records, including fees, labor, supplies and postage.

Please note that it takes 7-10 business days for requests to be processed.

A minimum of 24 hours is required to process requests except in situations of a medical emergency. In the event your records are required prior to 7-10 business days you will be charged a \$25.00 fee.

I would like the information to be sent in following format:

- Hard COPY Fax E-mail in PDF file

(Please note: e-mail communication system is NOT secured. There is some risk that any health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties.)

Check this box if you want PDF files with your records to be locked. Password can be provided via phone or in person.

- I hereby agree to pay the charges specified above. I understand that my records cannot be released until PFC receives my payment.

I will pay with: Cash Check Credit Card (see Credit Card Authorization attached)

Please let me know how much these copies will cost via

- E-mail: _____
 Phone: _____

Please Send my Records to:

(Name and address/ EMAIL to which the records are to be delivered)

Information will not be released without a valid signature below. This authorization will expire in one year from the signature date. You can however, cancel this authorization in writing at any time.

Patient's signature (or legal representative)

Today's Date

Print Name

Telephone

I, (*partner's name please print*), _____, hereby authorize you to release any of my medical information to my partner and/or to the address provided above, including the results of laboratory tests for infectious disease/HIV, if applicable.

Partners's signature

Today's Date

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