

Patient's Request for Access to Protected Health Information

Are you the Patient?

- Yes No, I am the patients legal/personal representative.

**Note: if you are not the patient, you may be asked to provide supporting documentation to verify that you are authorized to make this request on behalf of the patient*

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

What types of records would you like?

- Medical Billing Both

**Please describe the specific records you're requesting to help us respond more completely to your request.*

Is there a deadline for this request?

**By Law we have up to 15 days to fulfill your request. However, if you have an urgent need for an upcoming appointment, please let us know and we will do our best to honor your deadline.*

Yes, I have a deadline: Date Needed: _____

No, just as soon as possible (within 15 days)

How would you like us to release the records? (Fees may apply, See attached List)

No Cost Options for Patient (Digital Versions):

**Patient Portal is accessible by patient at any time (through AdvancedMD) and provides access to the following information: Sleep Study Summary Results, Demographics, Billing Statements (&ability to pay bill) , Upcoming Appointment Forms, Patient Education/Information*

- Email (Encrypted/ Secure) Email (Unsecure)

**If requesting Unsecure Email, I Understand that sign unsecured email may place my PHI at risk, and accept the risk of sending my PHI via an unsecured mechanism*

Fax (50 page limit)

Per Page Fees May Apply: Paper by Mail Paper by In Person Pickup (Roseville Office)

For Additional Fee:

USB Flash Drive (.edf file- Required for Video/Audio) by Mail

USB Flash Drive by In-Person Pickup

All Patients (or personal representative's) requests for access to their health information and medical records are processed in the order received and reviewed by California Sleep Solutions.

Pricing Breakdown :

Printed Records :

First 50 pages, \$.20/each

Additional pages over 50 : \$.25/each

Other Fees:

USB Flash Drive: \$5

Postage: Flat Rate Envelope (Signature Required): \$9.85

*In Office Pickup at Roseville Office is a free option

Labor Costs for Preparation & Copying of PHI & Medical Records: \$25/hour

*Time charged based on method chosen and how long it takes to print/copy records or download/upload records to flash drive

Your Rights Under the Law:

- I may refuse to sign this authorization & my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and mailed to this address:
 - California Sleep Solutions, 1130 Conroy Lane Suite 600, Roseville, CA 95661
- My revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid.
- I have the right to receive a copy of this authorization.
- I may inspect & obtain a copy of my health information for which I am authorizing the use or disclosure for as long as the information is maintained by California Sleep Solutions.
- The location listed above will not receive compensation for the use or disclosure of my health information.
- I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

I have read and confirm the terms of access stated herein.

Patient or Personal Representative's Signature

Date

Print Name if Other than the patient

Telephone Number

Expiration:

*Unless otherwise revoked by the patient, this authorization for the release of PHI to the above-named individual will expire on the date specified below, event identified, or 12 months from the date signed, whichever occurs first.

Date of Expiration: _____

Event: _____

From (mm/dd/yyyy): _____

To (mm/dd/yyyy): _____

Additional Requirements:

Photo ID: Must include a legible copy of your Photo ID or other government-issued ID along with the authorization form for identity verification purposes. If picking up the records in-person, you will be asked to provide your photo ID at the time.

If you are someone other than the patient: In addition to a Photo ID, please include a copy of valid supporting documentation that gives you authority to request records on behalf of the patient (Exception: parents of minor patients).

Acceptable forms of documentation include:

- *Advanced Healthcare Directive (must be in effect at the time of requesting records)*
- *Death Certificate*
- *Executor of Estate (for deceased patients only)*
- *Power of Attorney (must include a provision that allows medical decision-making and/or release of medical records)*
- *Power of Attorney for Health Care (must include a provision that allows release of medical records)*
- *Or some other form of documentation (subject to final review)*

Return Address for Signed PHI request:

California Sleep Solutions
1130 Conroy Lane Suite 600
Roseville, CA 95661

Other Return Option:

Fax: (916)789-0529