Request for Patient Access to Health Information

Bakersfield Neuroscience and Spine Institute
2601 Oswell Street, Suite 101, Bakersfield, CA 93306
Privacy Official (661-872-9999) • Fax (661-872-9988)

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.

Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip _____

I hereby authorize Bakersfield Neuroscience & Spine Institute **to release information** to:

Name of Provider/Organization/Person: _____

_____

_____

Phone: _____ Fax: _____

I authorize Bakersfield Neuroscience & Spine Institute to **obtain information** from:

Name of Provider/Organization/Person: _____

_____

_____

Phone: _____ Fax: _____

Purpose of Request for Information:

☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other (specify below)

Other: _____

Information to be Released:

☐ All my health information pertaining to any medical history, physical condition and treatment received. _____ Initials

☐ Dates of Treatment _____

☐ Types of Treatment _____

( ) Operative Reports ( ) Radiology Reports ( ) Office Visits
( ) Other: _____
_____

Other Access:

__ Inspection. Please let me know when I may come to inspect the records, and the amount of the charge, if any. I understand that an employee of this medical practice may be present and that I may not make any marks or alter records in any way.

CHARGES

Inspection. I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of [$6.00] per quarter hour and I may be required to pay these costs before I may inspect the records.

Copies or Transfer. I understand that you may charge me a reasonable charge of up to twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available.

__ I hereby agree to pay the charges specified above.

__ Please call me to let me know how much these copies will cost.

__ Clerical fee of ____$30.00*_____. (Payable at time of request)

__ *If Chart is before 2012 there will be an additional $40.00 fee charged for the retrieval from storage.

__ I am requesting these records be provided without charge to appeal the denial of eligibility for Medi-cal, SSDI or SSI/SSP benefits. A copy of the program's denial notice is attached. I applied for these benefits on _____(date).

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: _____

PLEASE NOTE: ALL HIGHLIGHTED AREAS MUST BE COMPLETED. ANY MISSING INFORMATION MAY DELAY THE RESPONSE TIME FOR YOUR REQUESTS.