REQUEST FOR INSPECTION OR COPY OF PROTECTED HEALTH INFORMATION
Medical Records Department; 3115 E. Guasti Rd. Ontario, CA 91761
Servicing All Locations: Downey/ West Covina/Ontario/Upland/Covina/Pomona

FAX BACK TO MEDICAL RECORDS FAX#: (909) 786-4394

REQUEST SECTION

Patient Name: __________________________ Medical Record: __________________________

As required by the Health Information Portability and Accountability Act of 1996, you have a right to request the opportunity to inspect and/or copy health information that pertains to you. A “Health Care Provider” will evaluate your request and will either grant it, or explain the reason why the request will not be granted. In the event that your inspection/copy request is not granted you may request that the decision reviewed by our center’s Privacy Officer.

I, __________________________ hereby request ( ) TO INSPECT or ( ) A COPY OF the following health information pertaining to me, maintained at Centrelake Imaging & Oncology:

Date of Service: __________________________ Information requested for Inspection or Copying: __________________________

Signature of Patient/Guardian: __________________________ Date: ____________ Telephone Number: __________________________

X __________________________ ____________ X __________________________

REVIEW SECTION-INTERNAL USE ONLY: This section is to be completed by the reviewer.

Date Received: __________________________ Reviewed By: __________________________
Privacy Officer: __________________________ Review Date: __________________________

This inspection or copy request is hereby: Granted ______ Denied ______

If the request is denied, please indicate the reason for denial.

Reviewer’s Comments: __________________________ __________________________ __________________________

Signature __________________________ Date __________________________