Connie T. Tan, MD, FACOG
2485 Hospital Drive, Suite 251, Mountain View, CA 94040
Phone: 650-988-7688 Fax: 650-988-7638

Request for Patient Access to Health Information

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 hereby request access to health information for:

____

____

(Print Patient's name and address)

Date of Birth: ___________

SCOPE OF ACCESS REQUESTED

I would like access to:

- ☐ All the records ***or***
- ☐ The portion of records concerning:

____

____

____

TYPE OF ACCESS REQUESTED

- ☐ Copies. I would like copies of the requested records.
- ☐ Transfer. Please transfer copies of all requested records to:

____

____

(Name and address of health care provider to whom the records are to be delivered)

CHARGES

Copies or Transfers. I understand that I will be charged **$50.00** per copy of records.

By signing below, I hereby agree to pay the charges specified.

Signature: ______________________________ **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: ____