Roger A. Mann, M.D. Inc.
◆ORTHOPAEDIC FOOT & ANKLE SPECIALIST◆
80 Grand Ave., Sixth Floor, Oakland, CA 94612 / (510) 451-6266 FAX (510) 451-6260
Roger A. Mann, M.D.

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)

If known: Date of birth: _____

SCOPE OF ACCESS REQUESTED

I would like access to: ☐ All the records ***or***
☐ The portion of the records concerning:

_____

(Specify type of disease, accident, dates of treatment, or other portion of records you are interested in.)

TYPE OF ACCESS REQUESTED

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

☐ Copies. I would like copies of: ☐ All records requested ***or***
☐ All records other than X-rays or tracings

☐ Transfer. Please transfer: ☐ Copies of all records requested ***or***
☐ Original X-rays or tracings only

To: _____

_____

(Name and address of health care provider to whom the records are to be delivered or Fax number if applicable)

☐ I would like the information in the following form or format if it is readily producible in this form:
_____.

CHARGES

Copies or Transfer. I understand that you may charge me a reasonable charge of up to twenty-five cents ($0.25) per page. I further understand that there is a fifteen dollar ($15.00) charge for digital copies of any X-rays to be put on a CD.

☐ I hereby agree to pay the charges specified above. Please bill me.

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

☐ 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

Staff Use:

Faxed/Mailed By: _____ **Date:_____**

Oakland Bone & Joint Specialists
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Response to Request for Patient Access to Health Information

Dear _____:

We received your request for access to [your health information] [the health information of]

_____
(Patient's name and address)

❑ **Your request is granted.**

❑ You may come in and inspect the records on _____ (date and time within five (5) working days after receipt of request).

❑ We will send the copies you requested within fifteen (15) days of our receipt of your payment of $ _____.

❑ We will transfer the records you requested to:

_____
(Name and address of health care provider to whom records are to be delivered)
within fifteen (15) days of our receipt of your payment of $_____.
[This includes a $ ____ deposit fee, which shall be refunded when the original x-rays or other tracings are returned.]

❑ **Your request is denied. The reason is listed below (see check box(es))**

❑ This medical practice does not have the records requested.

☐ The information you requested is located at:

_____

_____
(Address or other contact information).

☐ **OR,** This medical practice does not know where the requested information is located.

❑ The records requested are not "patient records" under California law and were compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding.

- ❑ You are not allowed by law to access these records without the patient's consent.

Requests concerning minors:

- ❑ Physicians in California are prohibited by law from disclosing medical information concerning minors without the minor's written authorization with respect to medical care which is confidential between the physician and the minor.

- ❑ Your child's physician believes that allowing access to your child's medical records would be reasonably likely to cause substantial harm to your child. You have the right to have this decision reviewed by another health care professional designated by this medical practice who did not participate in the original decision to deny your request. If you would like this decision reconsidered, please complete the attached form and return it to us.

Requests for mental health records:

- ❑ You have requested mental health records and your physician believes that your access to this information would create a substantial risk of significant adverse or detrimental consequences to you. You have the right to have this decision reviewed by another health care professional designated by this medical practice who did not participate in the original decision to deny your request. If you would like this decision reconsidered, please complete the attached form and return it to us. You also have the right to have these records reviewed by another physician, licensed psychologist, marriage and family therapist or clinical social worker. Please let us know if you would like us to transfer copies of these records to another mental health professional by completing another "Request for Patient Access to Health Information" so stating and specifying the name and address of the professional to whom you want the records transferred.

Requests concerning incapacitated adults:

- ❑ Your charge's physician believes that allowing access to your charge's medical records would reasonably be likely to cause substantial harm to your charge. You have the right to have this decision reviewed by another health care professional designated by this medical practice who did not participate in the original decision to deny your request. If you would like this decision reconsidered, please complete the attached form and return it to us.

Sincerely,

_____

_____ _____

Print Name *Date*

NOTE: *If you believe your rights have been violated, you may file a complaint with this medical practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to our Privacy Officer at the address listed at the top of this form. You will not be penalized for filing a complaint. A complaint form is available from the Privacy Official listed above.*

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Request For Reconsideration Of Denial Of Access To Minor's Health Information

I understand that my request for access to _____ (*Name of Minor Patient*) dated _____ was denied.

I request that another health care professional who did not participate in the original decision to deny my request reconsider this denial.

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

Please indicate relationship to patient:

☐ parent or guardian of minor patient
☐ other: _____

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Decision on Reconsideration Of Denial Of Access To Minor's Health Information

Dear _____:

We received your request for reconsideration of our denial of access to the health information of _____.
(*Name of Minor Patient*)

Upon reconsideration, your request:

- ❑ is still denied.
- ❑ is granted.
  - ❑ You may come in and inspect the records on _____
    (date and time within five (5) working days after receipt of request).
  - ❑ We will send the copies you requested within fifteen (15) days of our receipt of your payment of $ _____.

Sincerely,

_____

_____ _____
Print Name *Date*

NOTE: *If you believe your rights have been violated, you may file a complaint with this medical practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to our Privacy Officer at the address listed at the top of this form. You will not be penalized for filing a complaint. A complaint form is available from the Privacy Official listed above.*

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Request For Reconsideration Of Denial Of Access To Incapacitated Adult's Health Information

I understand that my request for access to _____
(*Name of Incapacitated Adult Patient*) dated _____ was denied.

I request that this denial be reconsidered by another health care professional who did not participate in the original decision to deny my request.

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

Please indicate relationship to patient:

- ☐ guardian or conservator of an incompetent patient
- ☐ other: _____

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Decision on Reconsideration Of Denial Of Access To Incapacitated Adult's Health Information

Dear _____:

We received your request for reconsideration of our denial of access to the health information of _____.
(*Name of Incapacitated Adult*)

Upon reconsideration, your request:

- ❑ is still denied.
- ❑ is granted.
  - ❑ You may come in and inspect the records on _____
    (date and time within five (5) working days after receipt of request).
  - ❑ We will send the copies you requested within fifteen (15) days of our receipt of your payment of $ _____.

Sincerely,

_____

_____ _____
Print Name *Date*

NOTE: *If you believe your rights have been violated, you may file a complaint with this medical practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to our Privacy Officer at the address listed at the top of this form. You will not be penalized for filing a complaint. A complaint form is available from the Privacy Official listed above.*

Request for Patient Access Tracking Information

Name of Patient:

_____

Address:

_____

_____

For Office Use Only:

Date received:	Processed by:
Review Date:	Response Date:
Patient Follow-up: ☐ Yes ☐ No	Date of Patient Follow-up:
Practice Follow-up: ☐ Yes ☐ No	Date of Practice Follow-up:
Reconsideration Request: ☐ Yes ☐ No	Date of Reconsideration Request:
Practice Follow-up: ☐ Yes ☐ No	Date of Practice Follow-up:

Reviewer's Comments:

Action Taken: