City of Hope National Medical Center

ACCESS TO PROTECTED HEALTH INFORMATION (PHI) REQUEST FORM

Today's Date _____

Patient's Name: (last) _____ (first) _____ (middle) _____

Home Address: _____

Email Address: _____

Home Phone: _____ Date of Birth _____

I hereby request that City of Hope National Medical Center (COHNMC) provide me, or my personal representative, with: ☐ Physical copies

or ☐ Digital copies, or other method described below:

_____

or ☐ Access to review

the "Requested Information" checked below.

Requested Information – ***for the dates of service from*** _____ ***to*** _____

☐ **Complete Health Record**	☐ Operative Report(s)
☐ Chemotherapy Flowsheet(s)	☐ Outpatient Clinic Note(s)
☐ Consultation Report(s)	☐ Pathology Report(s)
☐ Discharge Summary(ies)	☐ Radiology CD/Film(s)
☐ Continuity of Care Document (Patient Summary)	☐ Radiology Report(s)
☐ EKG(s)	☐ Records brought to COHNMC
☐ History and Physical(s)	☐ Records from External Care Provider(s)
☐ Inpatient Rounds Note(s)	☐ Scan(s)
☐ Laboratory Report(s)	☐ Other
☐ Mental Health / Psychosocial Report(s)	☐ Other

☐ I am only interested in ☐ **a summary** or ☐ **an explanation** of the Requested Information checked above to be prepared by COHNMC at the actual cost of preparation.

I would prefer to ☐ Pick-up or view the requested Information at a mutually agreeable time and place,

or ☐ Have the Requested Information mailed to me at the following address:

_____

City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

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AFFIX PATIENT IDENTIFICATION LABEL HERE

MRN _____

Patient Name _____

Date of Birth _____

I understand that COHNMC may deny this request under limited circumstances as provided under federal and state law protecting the privacy of health information. I further understand that, except as otherwise provided under applicable law, I have the right to authorize a review of certain of my records by a licensed physician or surgeon, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker designated by my written authorization.

I understand that COHNMC will notify me of its decision to approve or deny my request to inspect the Requested Information within five (5) working days of receiving this request. I understand that COHNMC will either deny my request to obtain a copy of the Requested Information or send me the copy within fifteen (15) calendar days of receiving this request. If I request a summary or explanation, COHNMC will try to complete it within ten (10) working days of receiving this request. However, COHNMC is unable to meet that deadline, COHNMC may extend the time up to a maximum of thirty (30) calendar days, by notifying me in writing of its need for additional time to comply.

If I am granted access to the Requested Information, I understand that City of Hope has entered into a partnership with a copy service to provide patients and their representatives with the reproduction and delivery of medical record copies, either on paper or in digital format.

If I ask for physical or electronic (digital) copies of my medical records that fall outside of the scope of a complimentary, Pertinent Package, there will be a fee of:

- $0.25 per page, up to a maximum of $100.

Most requests will be processed within 3 business days, unless records from storage are required, in which case an additional 3 days may be needed. I understand that digital media on a flash drive will cost an additional $5.00.

If I ask to receive the Requested Information in the form of a summary or explanation, City of Hope may charge me:

- The actual cost of preparing a summary or explanation, plus any applicable mailing fees.

TERM: This Authorization shall remain in effect for a maximum of six (6) months from the date of signature, or until the _____ day of _____, 20_____ .

I agree to pay these charges as incurred.

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME

IF PERSONAL REPRESENTATIVE HAS SIGNED ABOVE, INDICATE YOUR RELATIONSHIP TO THE PATIENT: ☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other	REASON PATIENT DID NOT SIGN

Identity of Personal Representative verified via ☐ Photo ID ☐ Matching Signature ☐ Other, specify: _____

After you have completed this form, please return it by mail or by facsimile to the following address:

City of Hope National Medical Center
Health Information Management Services
Medical Record Correspondence Desk
1500 East Duarte Road, Duarte, California 91010-3000
Phone: 626-218-2446 Fax: 626-218-8443
Hours: Monday through Friday – 8:00 am to 4:30 pm

About Diversified

Diversified Medical Records Services is an outside company specializing in managing compliance and correspondence copying for medical facilities nationwide.

The company was founded in 1992, is fully HIPAA compliant, and adheres to all state and federal regulations concerning the release of protected health information (PHI).

Medical Record Fees

The state regulates the rates for copies of medical records and those are updated annually.

Diversified Medical Records Services tries to minimize your costs by offering you electronic options as well as a flat discounted rate.

Have a Question?

If you need further information, please call Diversified Medical Records Customer Service at (800) 359-8520.

Dear Patient:

City of Hope contracts with Diversified Medical Records Services to process medical record requests. A 'Pertinent Package' is available free of charge and contains information about your most recent encounter. There is a fee to process large medical records requests as specified below.

Instructions:

- Complete the enclosed authorization entirely. If any area is left blank, the form becomes legally invalid per federal law. If you already have a completed authorization, double check that it is complete, signed, and dated. Also make sure it has not expired.

  Best Practices: Complete the new authorization provided to ensure HIPAA compliance so that your request can be processed without further delay.
- Make a check or money order payable to City of Hope for the appropriate amount.

Options: <u>Please circle your choice:</u>

Complimentary Pertinent Package: A complimentary package of your most recent encounter will be provided at no cost. This will contain everything most physicians will need.

1. **Entire Chart (please allow 2-3 days to process):**
   - **Rate**: $0.25 per page to a maximum of $100.
   - **Down Payment**: Please pay a down payment of $15.00.
   - **Remaining Balance:** An invoice for the remaining balance will be sent to you. Once that is paid, the records will be mailed or available for pickup.

2. Digital Copy**:** Records copied onto a USB Thumb Drive will be $5.00 in addition to the above fees.

   E-mail address for electronic invoice:

_____

Mail **both** your payment **and** your completed authorization form to:

City of Hope National Medical Center
Health Information Management Services
Medical Record Correspondence Desk
1500 East Duarte Road, Duarte, California 91010-3000

<u>Request will not be processed without pre-payment</u>

DMRS
Diversified Medical Records Services, Inc.

Credit Card Authorization Form

Card Information

Card Type (Circle One): VISA MasterCard

Cardholder Name: _____ Exp Date _____

Card Number: ____ - ____ - ____ - ____ CVV: __ __ __

Billing Address: _____ Zip: _____

Customer Contact Information

Contact Name: _____

Telephone: _____ Fax: _____

Email: _____

Invoices Paid

DMRS Req. #	Patient Name	Customer Ref #	Amount Paid
			$
			$
			$
			$
			$

Amount to Charge: $ _____

FOR INTERNAL USE ONLY

Date:
Received By:

PO Box 239003
Encinitas, CA 92023-9003
Telephone: (949) 240-6242 | Fax (949) 489-7903