Tuolumne Me-Wuk Indian Health Center

REQUEST FOR COPY OF PROTECTED HEALTH INFORMATION

YOU HAVE A RIGHT UNDER FEDERAL LAW TO REQUEST A COPY OF YOUR HEALTH INFORMATION.

HOW TO REQUEST A COPY OF YOUR HEALTH INFORMATION:

1. **Complete the Request for Copy of Protected Health Information form**

   To prevent possible delays in processing your request, please carefully complete the form including:

   - Your complete address and phone number in case we need to contact you about your request.
   - The date by which you need the records in the section "Date records needed". For urgent requests, please call 1-209-928-5400.
   - If you are a parent/guardian or personal representative; please include your relationship to the patient in the section "Relationship to Patient" and provide the required documentation.
   - Please clearly state where and how you want the records to be delivered.

2. Return the request form using one of these methods:

- Fax: 209-928-5411 (If you are completing this request at a Tuolumne Me-Wuk Indian Health Clinic, you may ask a caregiver to fax the form on your behalf.)
- Mail: Tuolumne Me-Wuk Indian Health Clinic-Medical Records 18880 Cherry Valley Blvd., Tuolumne, CA 9537

Tuolumne Me-Wuk Indian Health Center

REQUEST FOR COPY OF PROTECTED HEALTH INFORMATION

Note: Most requests are sent within 15 business days. To avoid delays, please print clearly and sign. (*** = REQUIRED FIELDS**)

INFORMATION ABOUT THE PATIENT WHOSE RECORDS ARE BEING REQUESTED

*Patient Name: Last _____ First _____ MI _____
*Street Address: _____ Daytime Phone: _____
*City, State, Zip: _____ Evening Phone: _____
*Date of Birth: _____ ***Date Records Needed**: _____

***WHAT RECORDS ARE REQUESTED?** (check all that apply)

Location	TMWIHC
Primary Care - Tuolumne, CA	☐ Clinic
Primary Care - Sonora, CA	☐ Clinic
Dental - Sonora, CA	☐ Clinic
Behavioral Health - Sonora, CA	☐ Clinic
Physical Therapy - Sonora, CA	☐ Clinic

Location	TMWIHC
Behavioral Health - Tuolumne, CA	☐ Clinic
MEWU:YA - Tuolumne, CA	☐ Clinic
Podiatry - Sonora, CA	☐ Clinic
OB/GYN - Sonora, CA	☐ Clinic

Other Location: _____

***REQUEST RECORDS:** ☐ **TO** or ☐ **FROM**

☐ Patient addresss above **OR**
☐ Facility Name:_____
Street Address:_____
_____
City/State/Zip:_____

***HOW TO SEND RECORDS:**

☐ Mail to Recipient Address
☐ Fax to number: _____
☐ Email to: _____
☐ Other delivery method (describe):_____
_____

***VISIT DATE RANGE NEEDED (SELECT ONE):**

- Specific: (from) _____ (to) _____
- One-year history ☐ Other: _____

***INFORMATION NEEDED:**

- Provider documentation, medication list and diagnostic information: Lab, X-ray, EKG (these are the most commonly requested records)
- Reports ☐ Billing Records ☐ Other (specify): _____

Acknowledgments:

1. I understand that I may be charged a reasonable cost-based fee that covers the cost of copying, including supplies, labor, and postage. The fee may be 0.25 cents per page to copy and $16.00 per hour for labor, supplies and postage. Requests for patient records to be sent to other health care providers are free of charge.
2. I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).
3. I understand I must provide legal documentation if I am the guardian or Medical Power of Attorney.

***Patient/Legal Representative:** _____ ***Signature:** _____ ***Date:** _____
Relationship to Patient: ☐ Patient (self) ☐ Parent/*legal guardian ☐ *DPOA ☐ Other: _____
* Please attach proof of guardianship/DPOA (medical power of attorney) with this request.

OPTIONS FOR RETURNING THIS COMPLETED FORM:
Fax: 209-928-5411
Mail to:
Tuolumne Me-Wuk Indian Health Center – Medical Records
18880 Cherry Valley Blvd., Tuolumne, CA 95379

Date received: _____
Received by (Name/initial): _____
☐ Faxed ☐ Mailed ☐ Picked up
☐ Other (e.g., Patient portal)
Date completed:_____

Tuolumne Me-Wuk Indian Health Center

NOTICE OF COMPLETED MEDICAL RECORDS REQUEST

Regarding patient: _____

We received a medical records request on: _____

Enclosed is a copy of the completed request signed by both the patient and medical records clerk.

Fees:

- Charge per page: $0.25 (if applicable)
  Total pages printed: _____
  Total cost ($0.25 x number of pages copied): _____
- Charge for electronic media (CD or USB) (if applicable): _____
- $16.00/hour clerical time to: (if applicable)
  - ☐ Create CD and/or USB
  - ☐ Prepare an explanation or summary of the PHI

Total charge for medical records request: _____