Descanso Medical Center for Development & Learning (DMCDL)
1346 Foothill Boulevard, Suite 301
La Canada, CA 91011 818.790.1587

Request for Patient Access to or Transfer of Medical Records

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

____
(name and date of birth of patient)

SCOPE OF ACCESS:

☐ All records **or**
☐ The portion of the records concerning (be specific):

____
____

TYPE OF ACCESS REQUESTED

☐ Inspection. Please let me know when I may come to inspect the records, and the amount of the charge, if any. I understand that an employee of DMCDL may be present and that I may not make any marks or alter the records in any way.
☐ Copies.
☐ Transfer. Please transfer records to

____
____
____

Charges

Inspection. I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of $6.00 per quarter hour and I may be required to pay these costs before I may inspect the records.
*Copies or Transfe*r. I understand that you may charge me a reasonable charge of up to twenty-five cents ($0.25) per page, plus any additional reasonable clerical costs incurred in making the records available.

☐ I hereby agree to pay the charges specified above. I will pay the costs at time of delivery

☐ 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 ___________________________________