



City of Hope National Medical Center

Access to Protected Health Information (PHI) Request Form

Patient's Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_
Home Address: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby request that City of Hope National Medical Center (COHNMC) provide me with:

- Access (review) OR receive physical copies of the entire Medical Record.
OR receive physical copies of the "Requested Information" checked below.
I am only interested in the time period \_\_\_\_\_ through \_\_\_\_\_.

Requested Information - \$0.25 per page, \$0.50/microfilm page or the actual cost/radiology film.
Table with 2 columns and 10 rows listing various medical records for selection.

- I am only interested in a summary of the Requested Information requested below to be prepared by COHNMC at the actual cost of preparation.
I am only interested in an explanation of the Requested Information requested below 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:

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 COHNMC will charge me:

- \$0.25 per page for copies, \$0.50 per microfilm page, and /or the actual cost per sheet of film, plus any applicable mailing fees, for the copying services necessary to complete my request.
- The actual cost of preparing a summary or explanation, plus any applicable mailing fees, if I ask to receive the Requested Information in the form of a summary or explanation.

I agree to pay these charges to COHNMC as incurred. Date: \_\_\_\_\_

\_\_\_\_\_  
*Printed Name of Patient (or Personal Representative)*

\_\_\_\_\_  
*Signature of Patient (or Personal Representative)*

Please indicate your relationship to the Patient:

- Patient     Parent     Guardian     Conservator     Agent     Other

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 Management Services Department – BC03**  
1500 East Duarte Road, Duarte, California 91010-3000  
Phone: 626-256-4673 ext. 62446    Fax: 626-301-8443