UNIVERSITY OF SOUTHERN CALIFORNIA
PATIENT REQUEST TO ACCESS HEALTH INFORMATION

Date of Request: _____
Patient's Name: _____
Last First Middle
Date of Birth: _____
Phone Number: _____

I hereby request that my University of Southern California health care provider(s) provide access to or a copy of my:

☐ Hospital records
☐ Clinic/office records
☐ Records limited to a specific provider:
_____
☐ X-rays
☐ Lab results
☐ Billing records
☐ My complete patient record
☐ Summary of Requested Information at the cost of $_____.
☐ Other: _____
(please specify)

Note: Fees may apply to certain requests.

Date/Time Period
Specify date/time period for the information above:

_____

Format
☐ Paper Form
☐ Electronic Format (i.e., CD)

Delivery
☐ View Only: Date: _____
☐ Pick-up: Date: _____
☐ Mail: Date: _____

Information Excepted from Request

I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law. If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law (for example, a minor's receipt of contraception and/or family planning services).

Process if Request Denied

I understand that USC may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the USC who did not participate in the initial decision to deny my request.

I understand that USC 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 and within fifteen (15) days after receiving this request if my request is for copies, unless I agree to additional time to respond. USC will provide me with a summary of the Requested Information within ten (10) working days of receiving my request, or within a maximum of thirty (30) days if USC notifies me that more time is necessary, either because of the length of the record or because I was discharged from the hospital within the ten (10) day period to produce the summary.

Fees

I understand that USC will charge me **[$_____]** per page for the copying services necessary to complete my request, as well as any applicable mailing fees.

Signature of Patient (or Personal Representative)	Date
Printed name of Patient or Personal Representative	Date
Relationship of Personal Representative to Patient	