Health & Mental Health Services
REQUEST FOR ACCESS TO HEALTH INFORMATION

You may request to view your personal medical or related financial records ("health information") that we have regarding the healthcare services provided from the Center. You may also request copies of those records for yourself or a designated person by completing and submitting this form to the Los Angeles LGBT Center, Privacy Office, 1625 Schrader Blvd., Los Angeles, CA 90028. Copies of records can be picked up from the same address.

YOUR INFORMATION

Last Name, First Name, Middle Initial

Date of Birth

Street Address

City, State, and Zip Code

Phone

Email

Best way to reach you

Best time to reach you

1. **What is the reason for this request?**
   - ☐ Disability or Public Benefit Application
   - ☐ Change of Medical Provider or Insurance
   - ☐ Legal Purposes
   - ☐ Personal Request
   - ☐ Other: _____

2. **How do you want access to your records? (Select One)**
   - ☐ Email
   - ☐ Mail
   - ☐ Pick-up
   - ☐ Other: _____

3. **What type of records do you want to access?**
   - ☐ Visit Records (Medical, Psychiatry, and Mental Health)
   - ☐ Medication Records/Lists
   - ☐ Lab Results
   - ☐ X-Rays and Imaging Studies
   - ☐ Visit Billing Records
   - ☐ Other: _____

4. **Records requested are between these dates:**
   _____ to _____

5. **Records needed by:** (date) _____

I understand that my health information may include records relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), and/or treatment for alcohol and drug use and/or recovery services. I also understand that the Center must verify identity before releasing any requested records. I am aware that, within 15 calendar days after receiving your request, the Center will provide me with access to my records or a written reason why I cannot receive them.

_____ _____
Patient Signature Date

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THIS PAGE IS FOR INTERNAL USE ONLY

Access facilitated by (staff member name) _____

Date of Access: _____

Patient Identity verified by:
- ☐ Signature Match
- ☐ Govt Issued ID
- ☐ Patient Known
- ☐ Other: _____

Protected health information accessed:
- ☐ Visit Records (Medical, Psychiatry, and Mental Health)
- ☐ Medication Records/Lists
- ☐ Lab Results
- ☐ X-Rays and Imaging Studies
- ☐ Visit Billing Records
- ☐ Other: _____

Records accessed were between (date) _____ and (date) _____.

How access was facilitated:
- ☐ Email
- ☐ Mail
- ☐ Pick-up
- ☐ Other: _____

The undersigned confirms that access to protected health information was requested by and provided to the above noted patient, and further confirm that the accessed records are a true and correct copy.

Staff Member Name: _____ Signature : _____ Date: _____

Staff Member Name: _____ Signature : _____ Date: _____