

**FORMER PATIENT REQUEST FOR ACCESS AND/OR COPIES OF HEALTH RECORD
DSH-6803 (New 07/2025)**

Please Note: The information requested is for identification purposes only.

Patient Name:	Date of Birth:	SSN#(optional):
Address:	City/State/Zip:	Patient Case # (optional):
Phone Number:	Admission Date:	Discharge Date:

Check applicable box:

PHOTOCOPIES: I am requesting photocopies of my health record documents checked below.

EMAIL: I am requesting copies of my health record documents checked below, be sent via email to: _____

APPOINTMENT: I am requesting an appointment to come to DSH and view my health record.
Please note: I understand there may be fees associated with my request for paper or electronic copies.

You have the right to review your records within 30 days of receipt of this request, but no more than 60 days for records that are geographically dispersed, or inactive in central storage, in accordance with Civil Code Section 1798.34.

Check all applicable box(s) of patient information you are requesting to be sent to you:

Document:	Date:	Document:	Date:	Patient must initial for any of the below records:
<input type="checkbox"/> Diagnosis		<input type="checkbox"/> Results of Psychological/ Vocational Testing		
<input type="checkbox"/> Psychiatric Evaluation		<input type="checkbox"/> Medical/Neurological Assessments, Lab Tests (EEG, EKG, etc.)		<input type="checkbox"/> HIV/AIDS test results _____ (initial)
<input type="checkbox"/> Discharge Summary		<input type="checkbox"/> Legal		<input type="checkbox"/> Genetic test results _____ (initial)
<input type="checkbox"/> Psychosocial Assessment		<input type="checkbox"/> Other (specify):		<input type="checkbox"/> Substance use disorder treatment records _____ (initial)
<input type="checkbox"/> Treatment Plan		<input type="checkbox"/> Other (specify):		
<input type="checkbox"/> Seclusion/Restraint				

(If additional space is needed, attach a list of the requested documents)

Print Your Name: _____ Signature: _____

Please include a copy of your identification along with your request if available.

Health Information Management Department (HIMD) Use Only:
HIMD Receipt of Form Date/Time: _____ Record Review Appt. Date/Time: _____