# Mountain Vista Medical Center
## Patient Request to Inspect and/or Obtain a Copy of Protected Health Information

I desire access to and/or copies of medical information created and maintained by Mountain Vista Medical Center. I authorize Mountain Vista Medical Center to copy and/or disclose to me my health information.

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

**PURPOSE FOR USE / DISCLOSURE** _____

Approximate date(s) of service to be used/disclosed _____

**INFORMATION TO BE USED / DISCLOSED**

- ❑ Consultation Report(s)
- ❑ Discharge Summary
- ❑ EKG Reports(s)
- ❑ Emergency Room Record
- ❑ History and Physical
- ❑ Lab Reports
- ❑ Operative/Procedure Report
- ❑ Pathology Report
- ❑ Radiology Reports/films
- ❑ Other _____

I understand that this information may include information relating to: Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV): treatment for drug or alcohol abuse; or mental or behavioral health or psychiatric care, excluding psychotherapy notes.

I desire access to my protected health information as follows:

1. The information identified above should be sent to me at the following address:

   _____ _____ _____ _____
   Address City State Zip

2. I would like to pick up the information noted above on the following dates and time:

   _____ _____
   Date Time

3. I want to review my protected health information, but I do not need a copy. I would like to review the information noted above on the following date and time:

   _____ _____
   Date Time

I understand that Mountain Vista Medical Center may charge a fee for the cost of copying, mailing, or other supplies associated with this request (not to exceed the community standard), and such fees must be paid in advance.

I understand that Mountain Vista Medical Center may deny my request to inspect and obtain a copy of my protected health information in certain limited circumstances. I understand that if I am denied the opportunity to inspect and obtain a copy of my protected health information, I may request that the denial be reviewed in certain situations.

_____ _____
Signature of Patient or Patient's Representative Printed Name of Patient or Patient's Representative

_____ _____ _____
Relationship to Patient Date Daytime Telephone Number

| | | |
|---|---|---|
| | Account Number: | MR Number: |
| | Patient Name: | |
| | Admit Date: | |

| DOB | Age | Sex | HT | WT | RM-BD | PT | SVC | FC |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

Allergies:

Attending Physician Name:

Mountain Vista Medical Center
1301 S. Crismon Rd.
Mesa, AZ 85209