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here and send to
HIMS Scanning

**Request for Access to
Medical Information**

Patient's name: _____
 MRN: _____
 Primary Physician (Must be a CMG physician): _____
 Date of Birth: _____
 Address: _____
 Daytime Phone: _____ Evening Phone: _____

I hereby request that Camino Medical Group provide access to the medical record of the patient named above. I request this access be granted to:

Name of person to be granted access

Relationship to patient

- Self
- Patient's spouse/friend
- Adult child caring for parent (elder patient)
- Parent of the minor child (under age 12)
- Parent of the minor child (over age 12)
- Guardian of the minor patient*
- Conservator of the patient*
- Conservator of the patient (psychiatric)*

**Please furnish a copy of your conservator/guardianship papers with this request.*

The type of access requested: (check all that apply)

- View patient's Protected Health Information Make appointments for the patient
- Ask questions of physician Make medical care decisions, if patient is unable to

DATA AUTHORIZED FOR RELEASE: (Please check and initial.)	YES	NO	INITIALS
Drug/Alcohol Information	_____	_____	_____
Mental Health Information	_____	_____	_____

Name: _____ Relationship to Patient: _____
 Signature: _____ Date: _____

If you are a CMG employee, please route your request through your supervisor, who will then route it to the HIPAA privacy officer.