LANGLEY PORTER PSYCHIATRIC HOSPITAL AND CLINICS
UNIVERSITY OF CALIFORNIA SAN FRANCISCO
1600 Divisadero St. 7th Floor
San Francisco, CA 94143-1954
(415) 476-7330

REQUEST FOR PATIENT ACCESS TO MEDICAL RECORD

RE: Patient Name: _____DOB:____/___/____

Approximate Date(s) of Treatment: _____

I hereby request that Langley Porter Psychiatric Hospital and Clinics provide access to the medical record of the patient named above.

I request this access as the: (check one)

☐ Patient ☐ Parent of the minor patient ☐ Guardian of the minor*
☐ Conservator of the person, psychiatric* ☐ Conservator of person*

The type of access requested is: (check one)

☐ Inspection of the record supervised by hospital staff appointment only for one hour
☐ Copies of the following:
- ☐ Discharge Summary – Dates:_____
- ☐ Initial Evaluation – Dates:_____
- ☐ Progress Notes – Dates:_____
- ☐ Other (specify/Dates):_____
  _____
  _____

Copies required for the following purpose:_____
_____

Selected copies can be made at a charge of $0.25 per page. If you require copies mailed, actual cost of postage will be charged. Medical Records will contact you with the total amount due. When submitting payment make check or money order payable to "Langley Porter Psychiatric Hospital."

Daytime ( )
Name: (Print) _____Phone: _____

Signature: _____ Date: _____

Address: _____

Official paperwork confirming guardianship and/or conservatorship must be presented at the time of your appointment to allow permission for you to review/ request copies of the patient's medical record. A copy of this paperwork will be kept in the patient's medical record.

Mail completed form to the address at the top of the page.