MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

REQUEST TO ACCESS HEALTH INFORMATION

You have the right to request a review of your personal health information held by the County of Marin. You also have the right to request copies of the information. If you choose copies, a copy and retrieval fee may be charged, and copies can be picked-up or mailed to you after receiving your completed request form and verifying your identity. To request access to your health information, complete this form and mail or return it to:

County of Marin- Department of Health and Human Services
Behavioral Health and Recovery Services.
250 Bon Air Road. Unit B, Greenbrae, CA 94904
Phone: (415) 473-6779 / Fax: (415) 473-4113 / Email: bhrsmedicalrecords@marincounty.org
CC.HHSCompliance@marincounty.org
If your hearing is impaired call the California Relay Service: 711

Enter Client's/Individual's Information

		DATE:	HIPAA FILE NUMBER: (FOR HIPAA OFFICE ONLY):
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
SOCIAL SECURITY NUMBER **(OPTIONAL):**	COUNTY IDENTIFICATION OR RECORD NUMBER:	DATE OF BIRTH:	
ADDRESS:		CITY/STATE:	ZIP CODE:
DAYTIME TELEPHONE #: MAY WE LEAVE A MESSAGE?	EVENING TELEPHONE #: MAY WE LEAVE A MESSAGE?	EMAIL ADDRESS:	
BEST WAY TO REACH YOU:	BEST TIME TO REACH YOU:		

Enter Representative's Information (As Needed)

NAME OF REPRESENTATIVE	ROLE ☐ PARENT ☐ GUARDIAN	☐ PERSONAL REPRESENTATIVE ☐ OTHER _____	
ADDRESS:		CITY/STATE:	ZIP CODE:
DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:	EMAIL ADDRESS:	
BEST WAY TO REACH YOU:	BEST TIME TO REACH YOU:		

VERIFICATION: The County does not want someone to access your health information without your permission. Before we will review your request, you will need to verify your identity by providing one acceptable form of picture identification. An acceptable identification includes a California State Identification, California State Driver's License, U.S. Passport (unexpired or expired), unexpired foreign Passport with I-551 stamp or attached INS Form I-94, Tribal Identification Card, Alien Registration Receipt Card with photograph (INS Form I-151 or I-551) or Mexican Consular Card. **If you mail in this request, you will be required to attach a copy of your picture identification or if you drop off this request, you will be asked to present your picture identification at that time.**

Over →

VERIFICATION for Personal Representative: If the signer of this request is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the client in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer of this request is a personal representative and does not have formal legal authority to act on behalf of the client, the client must provide documentation, in writing, that appoints the person making the request as his/her personal representative. The documentation must be attached to this form.

Your Rights:

- You have the right to request access to your health information that is maintained by the County of Marin (Fire Department and Department of Health and Human Services Divisions of Aging, Behavioral Health & Recovery Services, Health Services, and/or Office of Finance).
- You have the right to receive a written response to your request within 30 days.
- If you request copies of your health information, a copy and retrieval fee may be charged.
- Your request may be denied if licensed health care professionals involved in your case believe that access to your information could be harmful to you or to others, or if your information was given to the County of Marin under the promise of confidentiality. If access is denied, you have the right to have another licensed health care professional, who was not involved in the original review, review your request.

Check the type(s) of information you are requesting:

☐ Medical Records relating to _____
(excluding HIV, STD, Mental Health and Substance Use Disorder related Information)
☐ Include Substance Use Disorder Information
☐ Include HIV or AIDS Information
☐ Include Mental Health Information
☐ Include STD Information
☐ Records from a specific visit (enter date and location of visit) _____
☐ Other _____

_____

_____

Place(s) where you received health services (*example: Public Health Lab, Dental Clinic or CSU*):

I am asking for access to my health information for the following time period:

FROM:	TO:

To get a copy of this form in other languages or an alternative format in compliance with the Americans With Disabilities Act, please call or write the County of Marin's Privacy Officer at the address given above.

Signature and Identity Verification

PRINT NAME AND SIGN (CLIENT OR PERSONAL REPRESENTATIVE):	DATE:
IDENTIFICATION TYPE PRESENTED TO VERIFY IDENTITY (TO BE COMPLETED BY COUNTY REPRESENTATIVE):	
IDENTITY VERIFIED BY (COUNTY REPRESENTATIVE'S SIGNATURE):	DATE:
NAME OF THE COUNTY REPRESENTATIVE THAT RECEIVED THIS REQUEST:	LOCATION: