

# Request for Access to Hospital Records or Other Documents

(By Authorized State or County Department of Public Health Representatives for Licensure and Other Statutory Purposes)

I, \_\_\_\_\_, do hereby certify that I am an authorized representative of the California Department of Public Health (or the \_\_\_\_\_ Department of \_\_\_\_\_ County which is under contract with the California Department of Public Health to carry out licensing functions) and have requested access to the medical records or other records and documents described below pursuant to a duly authorized investigation or inspection for licensure purposes. The authority for this request is contained in Title 22, California Code of Regulations, Section 70751 and/or Section 70733 and/or the following code section or other provision of law: \_\_\_\_\_.

My badge or other identification number is: \_\_\_\_\_

The name and address of the office/agency, where I am employed or for which I am an agent, is:

\_\_\_\_\_  
\_\_\_\_\_

Verification of my identity and authority may be obtained by telephone contact with one of the following named individuals:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Title: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Title: \_\_\_\_\_

Records or other documents or information that I am requesting include: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(requestor)

Print name: \_\_\_\_\_  
(requestor)

Recipient of Request:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_