PRISON MEDICAL RECORD REQUEST

2022
How to Request Medical Records from the prison?

602 Appeals Process

Frequently Asked Questions

More Frequently Asked Questions

Example Forms
The California State Budget approved reparations for survivors of forced or involuntary sterilization under California’s eugenics laws from 1909-1979 and survivors of involuntary sterilizations in women’s state prisons after 1979.

The State will transfer the approved $7.5 million in reparations to California’s Victims Compensation Board (VCB), a state agency that provides compensation and resources to people who have been harmed by a crime. In order for survivors to receive money as compensation for being wrongfully sterilized, you should begin gathering all medical records and submit an application to the VCB.

This booklet is a guide and resource on how someone currently or formerly incarcerated can access their medical records for their own personal records and observation.

Art by Leah Jo Carnine, as pictured in The Fire Inside Issue #59, Spring 2019
### 7385 Process for People Currently & Formerly Incarcerated

#### 1 Fill Out the 7385 Form

Blank forms can be found at prison health clinics or online at bit.ly/7385form (case sensitive). You only have to submit the first two pages (not the instruction sheets). Be sure to fill out Section V to access all of your records.

#### 2 Submit the 7385 Form

For formerly incarcerated people: Mail: Health Records Center, P.O Box 588500, Elk Grove, CA, 9575. Email: ReleaseOfInformation@cdcr.ca.gov. Fax: 916-229-0002

For currently incarcerated people: Mail: Address the envelope with your records request to "Health Records" and send it via prison mail.

#### 3 Record how/when/and from where you sent the form

This could be taking a note, saving an email, or keeping a receipt, or something similar. It is important to have proof in case the form is lost or CDCR neglects to respond.

#### 4 Time Limitations

If your records request is accepted, you will hear back from CDCR with 15 calendar days. If your request is not accepted, CDCR should notify you within 30 days.
If you are currently incarcerated or on parole and CDCR denies your medical records request through the 7385 process, you can appeal their decision. You can start this process by filling out a 602-HC form. Read the instructions below to learn more about the process.

01. 602 APPEALS PROCESS

02. Section A of the form asks you to specifically describe your issue. Section B asks what action you want taken to resolve the specific issue you described in Section A. An action request could be, "I need access to my medical records."

03. Keep a copy of your appeal, either by photocopying or by handwriting and keep all responses you get from CDCR.

04. The first time you appeal a specific issue, a CDCR Appeals Coordinator has to respond to you within 30 business days. You can appeal a specific decision up to three times—the final time is ruled on by the Chief of Inmate Appeals.
1. Will I have to pay to request or receive my medical records from CDCr?

If you have money in your trust account, you will be charged $0.10 per page. However, if you do not have money in your trust account, you will not be charged any money for making a 7385 medical records request.

2. What if CDCr sends me records, but they’re incomplete?

This may happen if you had any surgeries while imprisoned. In this case, you should request records directly from the hospital where you got surgery.

3. I'm on parole and CDCr denied my medical records request. What should I do now?

Start a 602-HC appeal process, which allows you to appeal any decision, action, condition, etc., of the CDCr. All housing units should have the 602 HC forms available.
MORE FREQUENTLY ASKED QUESTIONS

4. How do I access my medical records from a community hospital?

You will need to complete, and submit, an “Authorization for Use or Disclosure of Health Information” form along with a (readable) copy of a valid Photo ID... California Drivers’ License or Passport to the hospitals Health Services / Records Department. This can be done via email and there may also be a fee for this service.

5. I am incarcerated, how do I access my outside medical records?

You will need to write a letter directed to the Health Services/ Records Department requesting copies of his/her medical records along with copy of your State issued I.D. You will have to send via postal mail.
7385 Form
Example
All sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

### I. Patient Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CDCR#</th>
<th>Date of Birth</th>
<th>Street Address</th>
<th>City/State/Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### II. Individual/Organization Authorized to Release Personal Health Records if Other Than CDCR

<table>
<thead>
<tr>
<th>Name:</th>
<th>City/State/Zip:</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

### III. Individual/Organization to Receive the Information

[45 C.F.R. § 164.508(c)(1)(ii), (iii) & Civ. Code § 56.11(e), (f)]

The undersigned hereby authorizes CDCR's Health Information Management to release the health information pursuant to this authorization.

<table>
<thead>
<tr>
<th>Name:</th>
<th>City/State/Zip:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Relationship to Patient:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>Address:</th>
<th>City/State/Zip:</th>
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</table>

### IV. Authorization Expiration Event or Expiration Date for Release of Verbal Information/Written Correspondence

[45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

Unless otherwise revoked by the patient, this authorization for the release of health care information to the above-named individual/organization will expire on the date specified below, event identified, or 12 months from the date signed in Section IX, whichever occurs first:

<table>
<thead>
<tr>
<th>Date of Expiration:</th>
<th>Event:</th>
<th>From (mm/dd/yyyy):</th>
<th>To (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

### V. Health Care Records to be Released - General

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

I authorize records for the following period of time to be released (must be completed to receive records):

<table>
<thead>
<tr>
<th>From (mm/dd/yyyy):</th>
<th>To (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

- Medical Services
- Dental Services
- Other:

NOTE: Health records released as part of this authorization may contain references related to mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV medical conditions.

### VI. Health Records to be Released - Specify

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

<table>
<thead>
<tr>
<th>Record Type:</th>
<th>From</th>
<th>To</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

NOTE: Health records released as part of this authorization may contain references related to dental, medical, mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV conditions.

Requests for psychotherapy notes require a separate CDCR 7385 and may not be combined with any other request for health records.

- Psychotherapy Notes

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.
VII. Purpose for the Release or Use of the Information

45 C.F.R. § 164.508(c)(1)(iv)

☐ Health Care  ☐ Personal Use  ☐ Legal  ☐ Other (please specify):

VIII. Authorization Information

I understand the following:

1. I authorize the use or disclosure of my individually identifiable protected health information as described above for the purpose listed. I understand this authorization is voluntary.

2. I have the right to revoke this authorization. To do so I understand I can submit my request in writing to my current institution’s Health Information Management (health records). The authorization will stop further release of my protected health information on the date my valid revocation request is received by Health Information Management. [45 C.F.R. § 164.508(c)(2)(i)]

3. I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]

4. Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the protected health information, except with a written authorization or as specifically required or permitted by law. [Civ. Code § 56.13]

5. If the organization or person I have authorized to receive the protected health information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. [45 C.F.R. § 164.524(a)(2)(v)]

6. I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4) & Civ. Code § 56.11(i)]

7. Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information. [45 C.F.R. § 164.524(c)(4) et seq. & California Health and Safety Code § 123110, et seq.]

8. I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be redisclosed without my written consent unless otherwise provided for by the regulations.

IX. Patient Signature

45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Name: (Print):

__________________________

Signature: __________________________________________ Date: ____________________

If no expiration date is specified in section IV, this authorization will expire 12 months from this date.

Name of person signing form, if not patient (Print):

__________________________

Signature: __________________________________________ Date: ____________________

Describe authority to sign form on behalf of patient:

__________________________

Name of translator/interpreter assisting patient, if applicable (Print):

__________________________

Signature of translator/interpreter: __________________________________________ Date: ____________________

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 10/19)

Instructions

Note: Part IV is the request for release of verbal health care information or health care information as part of written correspondence, and Part V is the request for release of health care records.

Part I - "Patient Information": Records the patient's full name (last, first, and middle), CDCR number, date of birth, and address if he/she is paroled or released (incarcerated patients do not need to provide an address).

Part II - "Individual/Organization Authorized to Release Personal Health Records if Other Than CDCR": Records the name and address of the individual or organization authorized to release personal health records if other than CDCR.

Part III - "Individual/Organization to Receive the Information": Records who is to receive the information.

Part IV - "Authorization Expiration Event or Expiration Date for Release of Verbal Information/Written Correspondence": Used by the patient to limit the time period during which information may be shared.
- The patient may enter the date he/she wants the authorization to expire.
- The patient may enter an expiration event.
- The patient may enter a date range of information to be shared.
- If no expiration date is specified, this authorization is good for 12 months from the date signed in Section IX.

Part V - "Health Care Records to be Released - General": Contains a designated line for the date range of health care records to be released.
- "Medical Services" is checked when the patient wishes to have information released related to medical care.
- "Dental Services" is checked when the patient wishes to have information released related to dental treatment.
- "Other" is checked when the patient wishes to further restrict or further authorize the release of his/her medical information, and he/she is to write those wishes on the line provided.

Part VI - "Health Records to be Released - Specify": Health care information in this section requires a date range, additional signature, and signature date.
- "Communicable Disease" is checked when the patient wishes to have information released related to communicable disease testing and treatment. Communicable disease includes sexually transmitted infections.
- "Genetic Testing" is checked when the patient wishes to have information released related to genetic testing.
- "HIV Test Results" is checked when the patient wishes to have HIV test results released.
- "Medication Assisted Treatment Records" is checked when the patient wishes to have information related to medication assisted treatment released.
- "Mental Health Treatment Records" is checked when the patient wishes to have information released related to mental health treatment.
- "Substance Use Disorder Records" is checked when the patient wishes to have information related to substance use disorder treatment released.
- "Psychotherapy Notes" is checked when the patient wishes to have psychotherapy notes released. Requests for psychotherapy notes require a separate CDCR 7385 and may not be combined with any other request for health care records.

Under HIPAA, there is a difference between regular personal health information and psychotherapy notes. The following is HIPAA's definition of psychotherapy notes (§164.501):

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.
Instructions (continued)

**Part VII - “Purpose for the Release or Use of the Information”:** Should have at least one box checked. The patient may utilize this section to check the provided boxes or select “Other” and describe the reason(s) he/she wants to have the information released. If the patient does not want to designate a purpose, he/she may check the “Other” and state “At the request of the individual authorizing the release.”

**Part VIII - “Authorization Information”:** Below this section are eight points which detail patient rights in regards to authorizing release of information.

1. Tells the patient that he/she is giving authorization voluntarily.
2. Explains how to stop this authorization. The patient may revoke the authorization by submitting his/her request in writing to his/her institution’s Health Information Management. The authorization will be removed from the patient’s medical record when the revocation is received by Health Information Management.
3. Explains that signing this authorization is voluntary and will not affect treatment.
4. Explains that the recipient of the protected health care information under the authorization is prohibited from re-disclosing the information, except with a written authorization from the patient or as specifically required under law.
5. Explains that the released information may no longer be protected by federal privacy regulations depending on the intended recipient of the released information.
6. Explains that the patient has the right to receive a copy of this authorization. This will be sent to the patient by Health Information Management.
7. Explains that reasonable fees may be charged to cover copying and postage costs related to releasing the patient’s health information.
8. Explains that substance use disorder records are protected and cannot be disclosed without the patient’s written consent unless otherwise provided for by the regulations.

**Part IX - “Patient Signature”:** The bottom of page two is for the patient’s, his/her representative’s, or the translator/interpreter’s signature. The patient’s printed name, signature, and date are to be entered in the boxes provided. If this authorization is completed by a patient representative (e.g., power of attorney, estate representative, next of kin), his/her printed name, relationship to patient, signature, and date are to be entered in the boxes provided. Also attached must be a copy of either the Power of Attorney, letters issued in estate proceeding, or declaration of next of kin. If an interpreter/translator assisted the patient in filling out this form, his/her printed name, signature, and date are to be entered in the boxes provided.
Madera Community Hospital
Authorization for Use or Disclosure of Health Information Form
Example
Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: ___________________________ M# ___________________________
Address: ________________________________________________________________
City: ___________________ State: ________ Zip Code: _______________________
Phone: (_____) __________________ Alternate Phone: (_____) __________________
DOB: ___________________ Last 4 Digits of SSN: __________________________

I hereby authorize __________________________ [Name of physician, hospital or health care provider] to disclose to:

Name of Requestor: ___________________________
Address: ________________________________________________________________
City: ___________________ State: ________ Zip Code: _______________________
Phone: (_____) __________________ Fax: (_____) ___________________________

Purpose of requested disclosure:
☐ Medical Care ☐ Personal ☐ Other: ___________________________
Date of Service/V#: ______________________________________________________

This authorization applies to the following information:

☐ History and Physical ☐ Emergency Department Report
☐ Discharge Summary ☐ Pathology Report
☐ Operative Report ☐ Labs / X-rays
☐ Consultation reports ☐ Other: ___________________________

METHOD OF RELEASE:
☐ Pick up by Patient: ☐ Paper ☐ X-ray images on ☐ CD ☐ QR Code
☐ Pick up by other than patient: [PRINT NAME] ____________________________

H/MCH Auth form for Use or Disclosure of Health Information (rev. Dec 2020)
ALL ALLOWABLE CHARGES MUST BE PAID PRIOR TO MAILING RECORDS
EXPIRATION
This authorization expires (insert date):

NOTICE OF RIGHTS AND OTHER INFORMATION
I may refuse to sign this authorization. I have the right to receive a copy of this authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address: Madera Community Hospital, ATTN: Health Information Management, 1250 E. Almond Avenue, Madera, CA 93637

My revocation will be effective upon receipt, but will be limited to the extent that the requestor or others may have responded to this authorization. Treatment, payment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I UNDERSTAND THAT THIS AUTHORIZATION:
1. California law prohibits further use or disclosure of the information being released beyond the specific limits of this consent unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law;
2. Patient health information may be subject to re-disclosure by the recipient and will no longer be protected by Federal confidentiality laws (HIPAA);
3. Includes ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, or Acquired Immunodeficiency Syndrome (AIDS), or tests for, or Infection with Human Immunodeficiency Virus (HIV);
4. I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

SIGNATURE

Patient: __________________________ Signature: __________________________

Date / Time: __________________________

☐ Signed by other due to patient's condition at time of service

Other's Signature: __________________________ Relationship: __________________________

Printed Name: __________________________ Date/Time: __________________________

Attending must authorize release of Psychiatric and Chemical Dependency reports:
PLEASE CHECK ONE:  ☐ Authorize Release  ☐ Deny Release

Physician: __________________________ Signature: __________________________

Physician #: __________________________ Date / Time: __________________________ a.m./p.m.
Sacramento County
Authorization for Use or Disclosure of Health Information Form
Example
Client Name (First, Middle, Last): *Print Neatly*

Date of Birth: X-Ref #:

Address:

City/State/Zip Code:

Phone #: ( )

Email:

OBTAIN from (Individual or Entity that has the Protected Health Information):
Dept. of Health Services - Adult Correctional Health; 7001-A E. Pkwy, Sacramento, CA 95823

RELEASE (disclose) your Protected Health Information to:

Recipient Name:

Address:

City/State/Zip Code:

Phone #: ( )

Fax #: ( )

Email:

PURPOSE: The health information disclosed may only be used for the following purpose(s):

☐ Continuity of Care  ☐ Legal  ☐ Personal Use  ☐ Other:

INFORMATION TO BE RELEASED: Dates: from __________ to __________

☐ Medical Records  ☐ Mental Health Records

☐ Lab Tests  ☐ Radiology/EKG

☐ Medication  ☐ Consultation Reports/Physician Order

☐ Treatment/Personal Service Plan  ☐ Progress Reports/Notes

☐ Discharge Summary  ☐ Psychiatric/Psychological Assessment/Testing Results

☐ Social History  ☐ Billing or Payment Information

☐ Other (Must describe):

NOTE: Records relating to mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:

☐ Mental Health records  Signature:

☐ Alcohol/Drug dependency treatment records  Signature:

☐ HIV antibody test results  Signature:

EXPIRATION: This Authorization will expire on __________ date. (mm/dd/yyyy)
(Unless otherwise stated, the expiration date will be no more than one year from the date signed.)

REVOCATION: You or your personal representative can revoke this authorization at any time upon written request. Revocation will take effect upon receipt, except to the extent that others have acted upon this authorization prior to receipt of the revocation.

REDISCLOSURE: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or such disclosure is specifically required or permitted by federal or state law.

I understand that I have a right to a signed copy of this authorization.

/ / 
Client’s Signature  Printed Name  Date

/ / 
Personal Representative’s Signature  Printed Name  Date

STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE (Print Name):

(Rev. 05/15/20)
VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

VERIFICATION for Personal Representative: If the signer 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 individual 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 is a personal representative that does not have the legal authority, the patient must provide documentation in writing appointing this person as a representative and this documentation must be attached.

General Medical Records: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

HIV, Alcohol and Drug, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: “This information may not be disclosed to any one without the specific written authorization of the individual.”

This authorization is voluntary. The client’s health information may be protected under federal or state confidentiality laws. These federal or state laws may not apply to the person or organization receiving the information being shared. The client may choose not to sign this authorization and this will not affect their ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if client is eligible to enroll in the Sacramento County Health program, the client may not be able to show they qualify for these services.

(If applicable) Client understands that County of Sacramento has been asked to provide a health care service (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if client chooses not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to the client.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:
The authorization is missing the elements described below:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- A specific expiration date not to exceed one year from the client’s signature.
- Signature of the client or client’s personal representative and date.

(Rev. 05/15/20)
You can send questions to our coalition at comp4reprojustice@gmail.com

For more information about the compensation program and involuntary sterilizations, visit CCWP Reparations 4 Reproductive Justice Behind Bars, Back to the Basics, and Belly of the Beast Film.

Art of California Coalition for Women Prisoners