THE CENTER for Mental Health

Individual's Request for Access to Protected Health Information

Client Name: _____ **Client #:** _____ **Client DOB:** _____

This form must be completed by you, or the person legally authorized to act on your behalf.

I wish to access the following types of information in my records: (Please check appropriate boxes)

- ☐ Clinical Information
- ☐ Billing information
- ☐ Other Information *(please specify)* _____

If you are the personal representative of the client, please indicate the reason for the request below. For clients requesting PHI, this section is optional.

The reason for this request is as follows:

_____

_____

_____

If access is granted, I would like to: (Please check the appropriate box below.)

- ☐ Inspect my records. I understand that a licensed professional will assist me in understanding the records and that there is no fee for this service.
- ☐ Obtain copies of my records. I understand that the following fees will apply, and payment is required before I receive the copies of my records.
  - Under 10 pages in a calendar year: free
  - $14.00 for the next 10 pages after the first 10.
  - Copies greater than 20 pages will be charged $.25 for each additional page.
- ☐ Obtain a brief summary of my records which will be prepared by a clinician and/or supervisor. I understand that there is a fee of $25.00 for this service which must be paid before I receive a copy of the summary.
- ☐ Obtain a comprehensive summary of my records prepared by a clinician or supervisor. I understand that there is a fee of $100 which must be paid before I receive the summary.

If access is granted, I would like the copies: (Please check the appropriate box below.)

- ☐ Paper copy mailed to the following address:

  _____

  _____

- ☐ Electronically mailed to the following e-mail address: _____

I understand that I may be denied access to my records, in whole or in part, because of the potential risk to me or someone else, or for other legally permissible reasons. In some instances, The Center for Mental Health may review decisions of denial. If this occurs, the Center for Mental Health will inform me in writing of their decision, If the request was denied, the reason(s) for the denial, and the review process that I am entitled to.

_____ _____

Client/Representative Signature **Date**

_____

Relationship to Client

Reviewed 2/21/2019