Request to Access Protected Health Information Form

Case #: ____________

Individual Legal Name: ________________________________ Parent/Guardian Name: __________________________

Address: ___________________________________ City, State & Zip: _______________________________________

Phone Number: (   )________________ Alternate Number: (   ) ________________ Date of Birth: _____________

Are you requesting to take a copy of these records with you? ☐ Yes ☐ No

There is *no fee* for the first 25 pages. There is *a flat fee* of $35 for documents over 26 pages.
***** Please note: We have up to 30 days to process your request.***

Please specify the protected health information you would like to access:

☐ Recovery Plan ☐ Diagnosis ☐ Mental Health Screening ☐ Physician's Progress Note
☐ Service Access-Intake Assessment ☐Psychiatric Evaluation ☐ Appointment Information
☐ Medications ☐ Other Facility Form ☐ Other: ______________________________

Please check off why you would like to access your protected health information:

☐ Treatment/Continuing Care ☐ Billing/Insurance Claims ☐ Educational Placement/Assistance
☐ Additional Funding ☐ Legal Proceedings ☐ Other: ___________________________________

__________________________________ __________________________________
Individuals Signature Date Individual Printed Name

__________________________________ __________________________________
Authorized Representative Date Print Representative Name & Relationship

__________________________________ __________________________________
Witness Signature Date Print Witness Name