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 <u>no fee</u> for the first 25 pages. There is <u>a flat fee</u> 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: ____________________________
☐ Letter (Specify what you would like the letter to include):
- ☐ Dates of Treatment
- ☐ Current/Last Diagnosis
- ☐ Current/Last medications

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