CENTRAL
Behavioral Health

Request to Access Protected Health Information Form

Consumer Name: _____ Parent/Guardian Name: _____

Address: _____

Phone Number: _____ Consumer DOB: _____

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

There is no fee for the first copy requested. There is a $25 fee for any additional copies requested within 1 year of the original request.

****Please note: We have up to 30 days to process your request. Please indicate below if you need your request by a specific date.****

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

☐ Clinical Assessment ☐ Progress Notes ☐ Other-Please Specify Below:

☐ Psychological Evaluation ☐ Medication List _____

☐ Psychiatric Evaluation ☐ Letter _____

If you requested a letter, what information would you like included in the letter?

_____

_____

_____

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

_____

_____

_____

Please indicate a time that would be convenient for you to meet with us regarding your request. _____

_____ _____

Consumer Signature Date Print Consumer Name

_____ _____

Authorized Representative Date Print Representative Name & Relationship

_____ _____

Witness Signature Date Print Witness Name

CentralBH
Form #343
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