SAMPLE

CENTRAL
Behavioral Health

Request to Access Protected Health Information Form

Consumer Name: Jane Doe Parent/Guardian Name: _____

Address: 1234 Main Street Norristown, PA 19401

Phone Number: (222) 333-4444 Consumer DOB: 10/7/92

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 include my diagnosis and dates of attendance.

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

To provide the information to my probation officer.

Please indicate a time that would be convenient for you to meet with us regarding your request. Monday at 1:00 pm

Jane Doe	7/17/18	Jane Doe
Consumer Signature	Date	Print Consumer Name
_____	_____	_____
Authorized Representative	Date	Print Representative Name & Relationship
John Doe	7/17/18	John Doe
Witness Signature	Date	Print Witness Name

CentralBH
Form #343
Rev. 1/2017