SAMPLE

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
- ☐ Psychological Evaluation
- ☑ Psychiatric Evaluation
- ☑ Progress Notes
- ☑ Medication List
- ☐ Letter
- ☐ Other-Please Specify Below: ____________

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

N/A

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

For my personal records.

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

Jane Doe — Consumer Signature | 7/17/18 — Date | Jane Doe — Print Consumer Name

____________ Authorized Representative | ____ Date | ____________ Print Representative Name & Relationship

John Doe — Witness Signature | 7/17/18 — Date | John Doe — Print Witness Name

CentralBH
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