Request to Access Protected Health Information (PHI)
AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

By law an individual has the right to inspect, obtain, and/or request a copy of his/her PHI in the Designated Records that Iris Kuykendall, practicing as On Deck Counseling, PLLC, maintains.

Part I: Identifying information of the individual (patient) for whom access is being requested.

Patient's Full Name: _____
Patient's Date of Birth: _____/_____/_____ Patient's Age: _____
Patient's Address, City, and Zip: _____
Patient's Area Code and Telephone Number: _____

Part II: Authorization of Information to be released. Date authorization initiated: _____/_____/_____
Authorization initiated by: (patient, provider, other): _____
Place an "X" in the box next to the records you wish to inspect or obtain a copy of and indicate specific dates:

☐ Patient Attendance Records From: _____ To: _____

☐ Patient Mental Health Progress Notes From: _____ To: _____

☐ Patient Payment Records From: _____ To: _____

☐ Other: (describe in detail) _____
_____ From: _____ To: _____

Part III: By placing an "X" in the appropriate boxes below please indicate who and in which format/manner you wish to receive/review your information.

Send my PHI to: (select only one)
☐ Me (Patient) ☐ Me (parent/guardian) _____

☐ Designated Third Party: I request that Iris Kuykendall send my PHI as specified in Part II above directly to the designated third party listed below.
Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone Number: _____

Format/Manner: (select only one)
☐ Send electronic copy. Note: Information will be sent to the email address provided via secured (encrypted) email unless otherwise specified. Email address: _____
☐ Send paper copy of information via US Mail to: _____
☐ View in person. I understand that I will be contacted to arrange for this.

Part IV: **Authorization and Signature**: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I request that Iris Kuykendall provide access to my PHI as specified.

Signature of the Patient: _____ Date: _____/_____/_____
Signature of Personal Representative: _____
Title: _____ Date: _____/_____/_____

Part V: If Part IV is signed by a Personal Representative, please complete the information below. If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do not have to attach copies of these documents if already on file with Ms. Kuykendall.

Personal Representative's Full Name: _____
Relationship to Patient: _____
Personal Representative's Complete Address: _____
Personal Representative's Area Code and Telephone Number: _____
Personal Representative's E-mail address: _____

NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY

If you need assistance completing the form, please contact Iris Kuykendall.

Explanation, Definition, and Summary:

You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

You can ask me to correct health information about you that you think is incorrect or incomplete. I may say "no" to your request, but I'll tell you why in writing within 60 days.

For additional information regarding your rights, refer to the *Notice of Rights and Privacy Policy* you received at our first session. It is also posted on the forms page of my website – www.OnDeckCounseling.info - Please ask if you want another copy.

Psychotherapy notes: Notes that capture the therapist's impressions about the patient containing details of the conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. Psychotherapy notes can also be recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session. Psychotherapy notes are kept separate from the rest of the individual's medical record. Psychotherapy notes will not be released, except in specific situations or as required by law. Psychotherapy notes shall be maintained separately from the medical record and require a separate release request/authorization. Summary information (i.e., progress notes) such as current state of the patient, symptoms, summary of the theme of the psychotherapy session, diagnoses, medications, side effects, and other information needed for treatment or payment shall be placed in the medical record.