



COM-HPA-1020.01

Client Name: \_\_\_\_\_ INS. #: \_\_\_\_\_

DOB: \_\_\_\_\_

**ACCESS REQUEST FORM**

**Request to Review and/or Copy Health Information**

You have the right to review and copy medical information that may be used to make decisions about your care. To review and copy your medical information, contact the Regional Director or Privacy Officer. If you request a copy of the information, you may receive one copy each year at no cost. For any additional copies during the same year, you may be charged a fee for the costs of copying, mailing, or other supplies associated with your request. Your request to review and copy your medical information may be denied in certain limited circumstances. If you are denied access to all, or any part, of your medical information, you may request that the denial be reviewed. Information regarding how to initiate the review process will be provided in writing at the time of any denial of access to your medical information.

You have a right to review your records with Pathways staff within 3 days of your request and copies of records within 30 days. If the information is not at this location, you have the right to have records available to you within 60 days. If there are delays in getting you the answer, you will be told.

**Request to Review or/and Copy**

I hereby request to  Review  Copy

**The following information:**

- Comprehensive Assessments
- Treatment Plan
- Consents
- Progress Notes for the period of time from \_\_\_\_\_ to \_\_\_\_\_.
- Discharge Summary
- Financial Records (payments, authorizations)
- Other: \_\_\_\_\_

I understand there is specific health information to which this agency may deny access, without my having an opportunity for review, as follows:

- Psychotherapy Notes
- Information compiled for civil, criminal or administrative action or proceeding
- Health information subject to the Clinical Laboratory Improvement Amendments of 1988
- Records that are subject to the Privacy Act, 5U.S.C. 522a
- Health information obtained under a promise of confidentiality

I further understand there may be circumstances when a licensed health care professional may deny my request for access to my health information; and that I am allowed to request a review by another licensed health care professional.

Consumer Signature

Title, If Legal Representative

Phone #

Date

The requested information can be sent to the following:

Fax #: \_\_\_\_\_

OR

Consumer's Address: \_\_\_\_\_

*Request determination continued on next page*

Client Name: \_\_\_\_\_ INS #: \_\_\_\_\_  
DOB: \_\_\_\_\_

*This Section for Agency Use Only*

**Review of Request**

<b>Determination:</b>	<input type="checkbox"/> <b>REQUEST APPROVED</b>
Agency Responsibilities:	<input type="checkbox"/> Determination of method for Consumer access <input type="checkbox"/> Notice to Consumer of approved access <input type="checkbox"/> Offer Consumer summary of information <input type="checkbox"/> Notify Consumer of requirements for copies of health information
<b>Determination:</b>	<input type="checkbox"/> <b>REQUEST DENIED</b>
Reason for Denial:	<input type="checkbox"/> Reference made to another person could endanger that person <input type="checkbox"/> Access could endanger life or physical safety of Consumer or other(s) <input type="checkbox"/> Access requested by personal representative and access cause substantial harm to Consumer or other(s) <input type="checkbox"/> Other _____
Agency Responsibilities:	<input type="checkbox"/> Written Notice to Consumer of basis for denial <input type="checkbox"/> Provide Consumer with Opportunity to Request Review by licensed health care professional in Agency <input type="checkbox"/> Provide Consumer with Opportunity to Request Record be sent to a physician or psychologist of his/her choice
_____	_____
Regional Director, Designee, or State Privacy Officer	Date

**Request Denied-Second Review**

<b>Determination:</b>	<input type="checkbox"/> <b>REQUEST APPROVED</b>
Agency Responsibilities:	<input type="checkbox"/> Determination of method for Consumer access <input type="checkbox"/> Notice to Consumer of approved access <input type="checkbox"/> Offer Consumer summary of information <input type="checkbox"/> Notify Consumer of requirements for copies of health information
<b>Determination:</b>	<input type="checkbox"/> <b>REQUEST DENIED</b>
Reason for Denial:	<input type="checkbox"/> Reference made to another person could endanger that person <input type="checkbox"/> Access could endanger life or physical safety of Consumer or other(s) <input type="checkbox"/> Access requested by personal representative and access could cause substantial harm to Consumer or other(s) <input type="checkbox"/> Other _____
Agency Responsibilities:	<input type="checkbox"/> Written Notice to Consumer of basis for denial <input type="checkbox"/> Provide Consumer with contact information for US DHHS Secretary
_____	_____
Agency Licensed Health Care Professional	Date