Aurora Mental Health & Recovery

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AuroraMHR.org

REQUEST FOR CLIENT ACCESS TO PROTECTED HEALTH INFORMATION

I am requesting access to the protected health information of:

Client Name (please print)	Social Security Number	Date of Birth	AMHR CID

The information to be disclosed includes the following checked documentation:

_____ Medication History _____ Psychiatric / Psychological Evaluations
_____ Progress Notes _____ Service Plans _____ Lab Studies
_____ Discharge Summaries _____ Complete Record

Dates include: _____ Last 6 months _____ Last year _____ All Dates _____ Other: From_____To_____.
The purpose for the Release is: Disclosure of information directly to the client or legal representative per their request.

I choose the following method of access to my protected health information:
_____ **Copies of the record** (There is no charge for the first copy of records in a 12-month period.)
_____ **Review the record** onsite at Aurora Mental Health & Recovery. I understand that I must arrange a date and time with my therapist to review the record.
_____ **Written summary of the record** (I understand there will be a charge for a written summary of my record.)

This request will expire on _____ (date), or, if left blank, two years from the date of my signature.

Signature of Client or Legal Representative _____ Date _____

Please print name of Legal Representative _____ Phone _____

Street Address _____ City, State, Zip Code _____

If you are not the client, please identify your authority to act on the client's behalf by circling one of the following:

Parent of Minor / Guardian / Custodian / GAL / CASA / MDPOA / Personal Representative of Estate

I UNDERSTAND THAT, if access is denied, I have a right to a review by a licensed health care professional who is designated by Aurora Mental Health & Recovery to act as a reviewing official and who did not participate in the original decision to deny access to the record.

For Center Use Only

Request Granted: _____ Clinician Signature: _____ Date: _____

Request Denied: _____ Date *Notice of Denial* mailed to Requester: _____

Supervisor Signature: _____ Date: _____

Records copied by (please initial) _____ Number of pages _____ Date copied _____

Documents reviewed by (signature) _____ Date _____

Records sent (date) _____ via: Mail Fax Picked Up