REQUEST TO ACCESS PERSONAL HEALTHCARE INFORMATION

Patients Name:	Birthdate: - -
Street Address	Age:
City, State, Zip:	Phone: ( ) _____-_____
Maiden/Other Name:	

Clinician Name: _____

Name of person requesting records: _____

Relationship to the patient: ☐ Self ☐ Parent ☐ Stepparent ☐ Guardian ☐ Other _____

☐ **Specific date(s) of records you are requesting: _____-_____-_____ to _____-_____-_____**

OR

☐ **Entire Chart**

Check box(s) of what part of your medical record you want to access:

- ☐ Medical History Form
- ☐ Psychiatric/Psychological Initial Evaluation
- ☐ Psychological Testing done by PRA
- ☐ Progress Notes
- ☐ Consents/Intake/Authorizations
- ☐ Billing/Financial Information
- ☐ Entire Medical Record minus financials

The information may not include "psychotherapy notes".

☐ A. I have consulted with the privacy officer about these records and information and have decided that I want to (select one):

- ☐ Read and review printed copies of my medical records with a professional
- ☐ Receive a copy of requested records:
  - ☐ Mailed (address listed above)
  - ☐ Encrypted emailed to _____
  - ☐ Faxed: ( ) _____-_____ Attention:_____
  - ☐ Pick them up on _____-_____-_____ ☐ Schaumburg ☐ Vernon Hills ☐ Crystal Lake
- ☐ Receive a summary of treatment history

☐ B. Costs:

- ☐ I have been advised there is a $10 fee payable to PRA Behavioral LLC

☐ C. ☐ I have revised my request — this is a new request — Old request dated _____-_____-_____

_____ _____ _____

Signature of client (age 12 and older) Printed name Date

_____ _____

Witness Signature of legal representative

For Office Use Only

Date Form received: _____-_____-_____

Date Healthcare provider contacted: _____-_____-_____

Date response sent to patient: _____-_____-_____

Date patient responded to response from Healthcare Provider: _____-_____-_____

Comments/Outcome:

Decision of the health care provider:

1. ☐ I will comply with this request. I will provide these records in the form requested within 30 days of receiving this request.

2. ☐ I deny this request for the reason(s) listed below. You may not appeal my decision.
   - ☐ The information you are seeking is not in my records.
     - ☐ I do not know who has this information
     - ☐ I believe that this information is in the possession of _____.
   - ☐ I choose not to allow access to my "psychotherapy notes"
   - ☐ The information was or is compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
   - ☐ The information is not available to the client for inspection as permitted by federal law.
   - ☐ The information was obtained from someone who is not a healthcare provider and they were promised confidentiality, and your viewing of this information would reasonably reveal the source of this information.
   - ☐ Other reason _____.

3. ☐ I will partly comply with this request. I have removed parts of the record and will allow access to the remaining parts. My reasons for removing those parts are that:
   - ☐ I choose not to allow access to my "psychotherapy notes"
   - ☐ The information was or is compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
   - ☐ The information is not available to the client for inspection as permitted by federal law.
   - ☐ The information was obtained from someone who is not a healthcare provider and they were promised confidentiality, and your viewing of this information would reasonably reveal the source of this information.
   - ☐ Other reason _____.

4. ☐ I deny this request for the reason(s) listed below. As a licensed healthcare professional, it is my professional judgment that your access to this information is reasonably likely to:
   - ☐ endanger the life or physical safety of the individual or other person.
   - ☐ cause substantial harm to another person, who is not a healthcare provider but is referred to in the record.
   - ☐ cause substantial harm to the individual or to another person if the individual's personal representative is allowed access.
   - ☐ Other: _____.

5. ☐ I agree to provide a written summary of treatment.

If you disagree with my decision made for the reasons in above, you may have my decision reviewed by a licensed healthcare professional who did not participate in this decision. I will obey the decision of this person. This decision will be made within 30 days of receipt of this form, you will be notified within 15 days after that and I will act on the decision also within 15 days of being told of it. To arrange this review, please consult with the privacy officer. You may also file a complaint about my decision with the Secretary of the DHHS. Our privacy officer will assist you in doing this. If you have any questions or want to know more, please contact the privacy officer.

_____ _____
Signature of Health Care Provider Date

Privacy Officer: Paula M. Comm, MA Phone: 847-598-8224