PRA Perakis, Resis, Woods & Associates

Request to Access Personal Healthcare Information

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

Date(s) of patient's record to be accessed ____

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

Medical History
Other Specified: ________________
Psychiatric Evaluation
Psychological Tests
Progress Notes
Discharge Summary
Consents/Intake/Authorizations
Billing/Financial Information

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 (select one)

❒ to read and review printed copies of them.
❒ to read and review printed copies of them with a professional Date/Time: _____-_____-_______ __:___
❒ to read and review printed copies of them and receive a photocopy of these records.
  - I want this copy mailed (address will be what is on file unless specified differently)
  - I want them encrypted emailed to ____
  - I want them faxed to: ( ) _______-___________
  - I want to pick them up on _____-_____-_______ ○ Sch ○ VH ○ CL

❒ to receive a summary of the information in these records
❒ to receive a written explanation of the information in these records.
❒ Other ____.

B. Costs (select one)

❒ I have been advised of the cost of copying, postage, or providing a summary or explanation and have agreed to pay $________
❒ I have revised my request. See a version of this form 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:

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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: ____.

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