ACP ASSOCIATED CLINIC OF PSYCHOLOGY

Request for Access to Protected Health Information

As a client of ACP, you are entitled under federal law to view your personal protected health information maintained in a "designated record set" and/or obtain a copy of this information. In order to process your request for access to this information, please complete this form.

Client Name: _____ **Date of Birth:** _____

Please indicate which information you are requesting:

☐ Care Coordination Package (*includes Intake/Diagnostic Assessment, Treatment plan, and last two progress notes*)

☐ Intake/Diagnostic Assessment ☐ Progress Notes ☐ Treatment Plan ☐ Discharge Summary

☐ Psychiatric Notes ☐ Test Results/Evaluation ☐ Medication List

☐ Other (please specify): _____

AND/OR please indicate date span below (if none indicated, intake and last two visit notes will be released):

☐ Specific Dates _____

Please indicate below whether you wish to review the information only, obtain a copy, or both. If you select "copy", please indicate your method of delivery.

☐ View my protected health information; I understand ACP may have a staff member sit down with me as I review my health information.

☐ Copy of my protected health information. I understand that ACP may charge me a fee for the copies and that payment in full for the fees will be required before I can obtain a copy.

☐ I will pick up the copy when ready. Please call when ready at (list phone number): _____

☐ I would like ACP to mail the copy when ready to the following address:

_____

(Street Address/City/State/Zip)

I understand that ACP is given 30 days to process this request for access if the information is maintained on-site and that ACP may extend the deadline by an additional 30 days if client is notified in writing of the extension. I understand that client rights are limited to information in the "designated record set" as defined in Section 164.501 of the Code of Federal Regulations. I further understand that mental health records may not be released if the clinician can reasonably determine that the information is detrimental to the physical or mental health of the client. I also understand that if the records are released to me, the information may cause an unintended emotional reaction and I may wish to review these records with my provider. By signing below, I acknowledge and agree to the above conditions.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed: _____ Relationship: _____