Request by Client or Legal Representative to Access Medical Record

Client Information.

Name: Last______________________________ First______________________ Middle_____________

Client Date of Birth: _____________________ Phone: ____

Home Address: ____

Choice of Format. I am requesting in the following format:

a._____ paper sent to me at the following physical address:
____; and/or

b._____fax to the following number: ____

Information Requested:

Dates: Beginning ____________ and ending _____________

_____ Intake Information _____ Progress Notes

_____ Discharge Summary _____ Treatment Plan

_____ Diagnostic Assessment _____ Other (Specify)_______________

NOTICE: SMnBH may deny access to information under state and federal law in some circumstances. If SMnBH decides to deny access to all or part of the record, the decision to do so will be prompt and will advise reasons why and what options are available to file an appeal.

Our standard delivery time for records is 30 days but requests for extensive or non-recent records may take longer.

Date: __________________

Verification: Client or Legal Representative Signature____

If I signed as a Legal Representative, my relationship to the patient is: ____________________________________

Cost: SMnBH estimates that the cost of providing the record to be: _____________. In requesting the information, I agree to pay the reasonable charges for the record.

OFFICE USE:

Identity of Legal Representative verified by: Photo ID ___________Other: ____

Authority of Legal Representative verified by the following document:

________Divorce Decree/Temporary Order ________Letters of Conservatorship

________Letters of Guardianship ________Health Care Power of Attorney _______Other

Verified By: ____ Date ____

Forwarded to Provider: Date: _____________ Name: ____ Office______________________

Provider: HIPAA tracking complete: Date________________ ______ By____

CSSC: Tabbed chart rec'd from provider: Date ____________________ HIPAA tracking complete: Date _______ By ___________________

Records sent: Date ___________ Via: ____ Fax _____ U.S. Mail _____Other ____

I

________________________________ hereby waive Southern Minnesota Behavioral Health from the sole responsibility of maintaining the privacy of my medical record as by requesting my records from ___________________ to ___________________. Southern Minnesota Behavioral Health can no longer ensure what I do with my record and my protected health information.

As always, Southern Minnesota Behavioral Health will not release any information without my consent, but cannot accept responsibility for any of the information that I share from my requested copy of medical record.

Signature: ___________________________________

Date: ___________________________________