Client Name: ______________________

Client ID#: ______________________

REQUEST FOR PATIENT ACCESS TO THEIR PHI

This form is for client requests to access (view), receive, or send copies of their own medical information.
There may be charges associated with this request.

Address: ______________________________

____

____

Please check all that apply to your request:

- ☐ **I am requesting access to view my medical information from *South Community***
- ☐ **I am requesting paper copies of my medical records information for my pick-up for records from *South Community***
- ☐ **I am requesting electronic copies of my medical records information for my pick-up for records from *South Community***
- ☐ **I am requesting paper copies of my medical information be sent to (name, address):**
- ☐ **I am requesting electronic copies of my medical information (may include flash drives or emails) be sent to e-mail address):** ______________________________

PLEASE COMPLETE BACK OF THE FORM

Disclosure covers the following period of services: **From** (date) ______________ **to** (date) ______________

Information for review or copies, if included in my records:

☐ Complete record	☐ Psychiatric Evaluation	☐ Current Medications	☐ Treatment Plan
☐ Discharge Summary	☐ Psychological Evaluation	☐ Laboratory Reports	☐ Service Dates
☐ Diagnostic Assessment	☐ Medication History	☐ Progress Notes	☐ Diagnosis
☐ Other: ______________________			

Please note any medical information sent via unsecured e-mail is inherently not secure and could result in the information being read or otherwise accessed while in transit.
Please let *South Community* know if you do not want your information to be sent via e-mail.

Name used when Treatment occurred: ______________________________ **DOB:** ______________ **Phone #:** ______________
First **MI** **Last**

____ **Date:** ______________
Client Signature

____ **Date:** ______________
Legally Responsible Other

______________________________ ______________________________
Relationship, if not client **Staff Facilitating Request**

Official Use Only

Name of Person Releasing Information: ______________________ **Date of Release:** ______________

Reviewed on-site or format of copies: ______________________ **Fee charged:** ______________

This form does not replace the Authorization for Release of Information Form currently used by the agency, but rather is to be used when the client or client's guardian makes a request for their records.

It is a HIPAA rule that clients can request their records for themselves or request their records be disclosed to a third party. This form is to be used for that purpose. This form is a one-time use form and will need to be completed with each subsequent request the client makes.

The Authorization for Release of Information Form will continue to be used for communication/disclosure to other entities/persons.

Reference: 45 CFR 164.524

GUIDELINES FOR E-MAIL COMMUNICATION WITH PERSONS SERVED

______________________________ ______________________________
Print Client Name Client ID#

When e-mail is used for a person served, workforce member must advise the person served, his/her parent, legal guardian or authorized representative of the following:

(Client to initial each statement below)

1. There are possible risks of using e-mail, such as technology failure (time lags, hardware defects, and power outages) and confidentiality/security risks (lack of encryption, third party interception, and misdirected e-mail).

   _____ Initial

2. E-mail is treated with a high level of confidentiality, but also is subject to South Community Inc.'s/SCPC's internal monitoring procedures for quality improvement.

   _____ Initial

3. If an e-mail address is shared with others, such as a spouse, significant other, friend etc., the individual will be privileged to the persons served PHI and his/her confidentiality will be compromised.

   _____ Initial

4. The person served should not use e-mail to communicate crises or emergencies. Workforce member will advise the person served or his/her parent, legal guardian or authorized representative of emergency procedures including 24-hour phone access.

   _____ Initial

The person served has the right to request that the e-mail **NOT** be encrypted

E-mail communications will become part of the client electronic health record. (Scan into e-docs, under correspondence, incoming or outgoing as applicable

______________________________ ______________________________
Client/Guardian Signature Date Staff Signature Date

______________________________ ______________________________
Print Guardian Name/Authorized Representative (If Applicable) Print Staff Name