	The Counseling Center of Wayne and Holmes Counties
	Request for Access to Health Information

SECTION A: Client to complete the following information.

NAME:_____ BIRTH DATE:_____

ADDRESS:_____

TELEPHONE:_____ DATE:_____

REQUEST:

I hereby request that The Counseling Center provide me with **(check all boxes that apply)**:

☐ Access to, or
☐ Copy of the requested information checked below:

- ☐ Medical records for the individual named above.
- ☐ Billing records for the individual named above.
- ☐ Any other personally identifiable information used by The Counseling Center to make medical decisions about for the individual named above. Please describe:
  _____
- ☐ All requested information for the individual named above maintained by The Counseling Center.

☐ A summary of the requested information for the individual named above.

I am interested in accessing ☐ or obtaining a copy ☐ of the requested information relating to the following time period: Start Date _____ through
End Date _____.

COSTS:

All costs/charges for copying materials, chart review and summary report preparation are the responsibility of the client requesting the information. A small charge for postage may also be added if necessary. An estimate of the charges can be provided once the amount and type of information being requested has been made.

NOTIFICATION:

I wish to receive the requested information in the following format:

☐ Photocopies ☐ Electronic transmission (if available) ☐ Other (if available) _____

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Client Name _____ Case Number_____
cc: Medical Records
DSD (01/03) (Rev. 04/04)
(QA 11/04)

SECTION B: The Counseling Center to complete this section.

Request for access or copy is: □ Accepted □ Denied

If denied, check the following reason for denial:

- □ PHI is not part of the client's designated record set.
- □ Federal law forbids making the requested information available to the client for inspection (e.g., CLIA or Privacy Act of 1974).
- □ The requested information is psychotherapy notes.
- □ The requested information has been compiled for legal proceeding.
- □ The requested information was obtained under promise of confidentiality and access would be reasonably likely to reveal the source of the information.
- □ Licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others.
- □ Licensed health care provider has determined that the requested information identifies a third person that may be physically, emotionally, or psychologically harmed if access to the information is granted.
- □ Licensed health care provider has determined that access to the requested information by the client's legal representative could result in harm to the individual.
- □ We are acting under the direction of a correctional institution and letting the inmate access or obtain a copy of the requested information would jeopardize the health, safety, security, custody, or rehabilitation of another person at the correctional institution.
- □ The requested information is not maintained by our facility.

RIGHT TO REVIEW:

You □ do □ do not have the right to a review of this denial. Contact Privacy Officer to arrange for the review. If you are not satisfied with the outcome of the review, you may file a complaint with me and/or The Counseling Center's Client's Rights Officer Michael R. Hamill, LPC, LSW. Mr. Hamill may be reached at (330) 264-9029 weekdays from 8:00 am –5:00 pm. You may also file a complaint with the Secretary of the Department of Health and Human Services.

_____ _____

Diane S. DeRue, MPA, LSW Date
Compliance and Privacy Officer

Client Name _____ Case Number_____

cc: Medical Records