Request For Access to Protected Health Information

I hereby request access to the Protected Health Information (PHI) about me that has been created or is maintained by **Vail Place**.

My Information:

Full Legal Name:	Date of Birth:	
Address:		
City:	State:	Zip Code:
Phone Number:	Email Address:	

Please note the following:

1. **Vail Place** will respond to your request promptly; no later than 30 days from the request.
2. We may deny access to protected health information in certain situations and conditions. If you are denied access to any portion of the protected health information requested, we will notify you in writing of the reason for the denial. We will also inform you of any rights you may have to have the denial reviewed.
3. You may refuse to sign this authorization. Your refusal will **not** affect your ability to obtain treatment, but you will not be able to obtain copies of your records without signing this form.

Time Period of Request

I am requesting access to the PHI created or received by **Vail Place** between:

____/____/_____ and ____/____/_____ (mm/dd/yyyy).

If not specified we will provide records for one year from date of request.

Information Being Requested

I am requesting access to the following PHI created or maintained by **Vail Place**:

- ☐ Treatment or Goal Plans
- ☐ Clinical assessments or records
- ☐ Diagnostic Assessments or other records documenting eligibility for Vail Place services
- ☐ Authorization to Release Information forms
- ☐ Information recorded in the Client Profile
- ☐ Progress notes or records documenting services provided by Vail Place employees
- ☐ Progress notes or records received from other providers
- ☐ All records
- ☐ Other (describe the information as specifically as possible):

_____

_____

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Location to Send the Information

I am requesting that the PHI be delivered to me as follows:

- ☐ I will pick up printed copies of my PHI
- ☐ Please fax copies of my PHI to the following number: _____
- ☐ Please securely email copies of my PHI to: _____
- ☐ Please mail the copies of my PHI to the address provided above
- ☐ Please mail the copies of my PHI to the following address:

Name:		
Address:		
City:	State:	Zip Code:

Individual's (or Legal Representative's) Name:

_____

Individual's (or Legal Representative's) Signature:

_____ Date: _____

Capacity or Authority of Legal Representative (if applicable):

- ☐ Guardian
- ☐ Other legal representative: _____