PLAINS AREA
Mental Health Center
Helping People Cope with Everyday Living

Request to Review or Obtain Copies of Protected Health Information

Client First Name: _____**Client Last Name**: _____

Date of Birth: _____**Telephone Number**: _____

Address:_____City:_____State:_____Zip_____

Record request for information on the following (include type of records and dates of services):

_____

_____

Check One Below:

____Information is to be copied and mailed to_____

____Information to be emailed to_____Please note that any information sent electronically is sent secure and will require an account with password to be established in order to access the information.

____Information to be review with Plains Area Mental Health staff. Please provide telephone number where we can contact you to arrange a date and time for review: _____

I as the client acknowledge, I have received a copy of Plains Area Mental Health, Inc. Notice of Privacy Practices and understand that in certain instances access to the above requested information may be denied. By accepting this request, Plains Area Mental Health, Inc. only agrees to review the request and determine if access will be granted. I understand that Plains Area Mental Health, Inc. has 30 days in which to act upon this request if the information requested is kept, or 60 days if the information is kept off-site. Plains Area Mental Health, Inc. may also request an extension if I am notified with in the original timeframe. If the request is denied, I understand that I may request a review of denial according to Plains Area Mental Health, Inc. review procedures. I also understand that if my request is granted that I may be charged a fee for the cost of copying and mailing the information.

_____ _____

Signature of Client or Guardian/Legal Representative **Date Signed**

_____

If signed by Guardian/Reprehensive state relationship to client