Plains Area Mental Health Center

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

You have the right to inspect your protected health information (PHI) in records, which Plains Area Mental Health Center creates or maintains. You also have the right to request copies of those records. You may be charged for the costs of copying and mailing for some records. You will receive a response to your request within 15 days after we receive your request and payment (if payment is applicable)

CLIENT INFORMATION

FIRST NAME	LAST NAME	MIDDLE INITIAL
DATE OF BIRTH	ADDRESS	ZIP CODE
CITY/STATE	TELEPHONE NUMBER	
EMAIL ADDRESS (If requesting this be processed via electronic communication)		

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?

(Include type of records and dates of services):

METHOD OF ACCESS

Please check one below:

- ☐ WILL PICK UP AT PAMHC OFFICE LOCATION: _____
- ☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION TO THE ABOVE ADDRESS.
- ☐ PLEASE EMAIL COPY OF THE REQUESTED INFORMATION AT THE EMAIL ADDRESS LISTED ABOVE. (Please note electronic communication via email will be encrypted.)
- ☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON. (IF YOU REQUEST TO REVIEW RECORDS IN PERSON, YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.)

CLIENT SIGNATURE

I, as the client acknowledge, 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 within 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: _____ **Date:** _____

Signature of Guardian/Legal Representative:_____ **Date:** _____

If signed by Guardian/Reprehensive state relationship to client: _____