REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Request for access to protected health information regarding: _____
Client Name (please print)

____/____/____
Date of birth

Information sought:
- ☐ Dates of Service
- ☐ Medication History
- ☐ Diagnosis
- ☐ Intake/Discharge Summary
- ☐ Psychiatric Evaluations
- ☐ other: _____

The Network will approve or deny this request within 30 days of receipt if the record is on site. If not, the Network will have 60 days to approve or deny. The Network may extend those time periods, if needed, and you will be notified if that is the case.

I UNDERSTAND THAT PURSUANT TO COLORADO LAW, before access to a mental health record is granted or denied in some cases, the Network may request that a physician who practices psychiatry and is an independent third party review the record and consult with Network staff. I hereby grant permission for such a review.

I choose the following method of access to the medical record:

- ☐ Arrange a date, time and location to inspect the record.
- ☐ Have copies of the record made available to me, and I agree to pay copying charges, which are $5.00 for the first ten pages or fewer, $.50 per page for pages 11 – 40, and $.33 per page for every additional page. If mailed to me, I agree to pay the additional cost of postage.
- ☐ Be provided a narrative summary of the record and agree to pay $_____ for the summary.

_____ _____
Signature of Consumer or Legal Guardian — Date

_____
If not the consumer, print name and legal authority

Mailing Address: (Required)

_____
_____
_____
_____
_____

Phone: _____

- ☐ Mail
- ☐ Pick up