Mental Health America of South Central Kansas

REQUEST FOR COPY OF PROTECTED HEALTH INFORMATION

Complete this form and return it to the privacy officer.

Requestor's Name: Last	First:	Middle:

Street address:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Client's Name if Different from Requestor	Client's Date of Birth

Relationship of Requestor to Client

❑ Self ❑ Parent ❑ Guardian ❑ Other _____

INFORMATION REQUESTED

☐	Admission Evaluation	☐	Progress Notes
☐	Diagnosis	☐	Alcohol and Drug Treatment Information
☐	Treatment Plan – Treatment Plans include diagnosis, prognosis, goals, objectives, and progress. Treatment Plans are provided to clients free of charge whenever requested.	☐	Hospitalization Screening
☐	Psychiatric Consult Report	☐	Explanation or Summary of protected health information
☐	Psychological Evaluation Report	☐	Other Click or tap here to enter text.
☐	Discharge Summary	☐	Other Click or tap here to enter text.

From Date Click or tap here to enter text. to Click or tap here to enter text.

Mental Health America of South Central Kansas

FORMAT REQUESTED		
❑Paper* ❑Pick-up ❑Mail	❑ Fax Fax Number:	❑ Email ** Email Address

* MHA requires a payment of $15.00 for all requests of paper records. This amount must be paid prior to the request being processed.

**If you want to receive your protected health information via email, please note MHA cannot guarantee encryption of these records. These records may be at risk for inadvertent disclosure. By providing your email address, you accept this risk.

CONSENT

I understand that the HIPAA Privacy Rule sets forth certain types of protected health information that are not subject to a request for access, including, but not limited to, a request for access to psychotherapy notes or a request for access to protected health information when a licensed health care provider has determined that access is likely to endanger the life or physical safety of any person. In such a case, MHA does not have to grant access to the requested protected health information and will provide me with notification of the denial, in writing, the reason for the denial, and whether the denial is subject to an appeal.

Signature of patient or personal representative	Date
Signature of Witness (if signed with an X)	Date

OFFICE USE ONLY

ID verified by (must use 2):

☐SS Number ☐Date of Birth ☐Phone

☐Address ☐Date of last appointment

☐Last provider seen ☐State picture ID

☐ Paid Receipt # _____ ☐ Not Paid

☐Form completed over the phone by (staff's name) Date staff completed form.