REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request access to the protected health information about me that has been created or is maintained by **Vail Place**.

INDIVIDUAL WHO IS THE SUBJECT OF THE PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: ____/____/____ (mm/dd/yy)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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.
4. There is a charge for requesting copies of your records. A summary of charges is outlined in the Records Request Fees section of this form.
5. Vail Place will not charge for records requests in some situations, as outlined in our "Individual's Right to a copy of their PHI" policy. Please see the Records Request Fees section of this form for more information.
6. You may request that we mail your information to you, if you agree to shipping and handling costs as identified in the Records Request Fees section of this form.
7. You may request a summary of the protected health information, if you agree to any cost associated with producing the summary.

TIME PERIOD OF REQUEST

I am requesting access to the protected health information created or received by **Vail Place** between:
____/____/____ and ____/____/____ (mm/dd/yy).

INFORMATION BEING REQUESTED

I am requesting access to the following protected health information 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
☐ Other (describe the information as specifically as possible):

_____

_____

_____

_____

RECORDS REQUEST FEES

In some situations, Vail Place will not charge for records requests. Please contact the Supervisor handling your request if you believe it meets any of the following conditions:

- for the purpose of reviewing the individual's current medical care, defined as: the most recent Goal Plan, Functional Assessment, LOCUS and/or Crisis Plan created by Vail Place; current Authorization to Release Information forms; and last six months of Progress Notes; or
- for the purposes of appealing a denial of social security disability income or social security disability benefits under the Social Security Act; or
- for the purposes of further appeals, an individual may receive no more than two updates of their information without charge, but only for information previously not provided.

☐	CHARGE:	COST:	SUPERVISOR COMMENTS:
☐	Records Preparation (required)	$15.00	
☐	Copies of records – per page (required)	$1.00 X _____	
☐	Shipping and handling (optional)	$5.00	
☐	Summary of Protected Health Information (optional*)	$20.00	
☐	Other charges – determined at discretion of Vail Place's HIPAA Privacy or Security Officer		
	ESTIMATE OF COSTS:		

*If you only request a Summary of Protected Health Information, you will not be charged records preparation and copying fees.

LOCATION TO SEND THE INFORMATION

I am requesting that the protected health information be delivered to me as follows:

☐ I will pick up the copies of my protected health information;
☐ Please fax copies of my protected health information to the following number: _____
☐ Please provide an electronic copy of my protected health information (CD format)
☐ Please mail the copies of my protected health information to the address provided above
☐ Please mail the copies of my protected health information 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): _____
*May be requested to provide verification of representative status.

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