Pauquette Center for Psychological Services

HIPAA – Request for Access to Health Information

Date _____

Client _____ Date of Birth _____ Age ____ Phone _____
(Please print)

Address: _____

1) I am requesting to:
   - □ Inspect my health record
   - □ Obtain a copy of my health record
   - □ Receive a letter summarizing the health information desired (as an alternative request)

2) Please state why you are requesting your health records.
   _____

3) Please describe the specific information or records that you are requesting and the time period.

□ Intake Summary	□ Case Notes	□ Medication Records
□ Treatment Plan	□ Psychiatry Records	□ Psychological Evaluations
□ Discharge Summary	□ Other _____	

   Time period: Beginning date _____ Ending date _____ Other _____

4) By my signature below, I acknowledge the following:
   - Inspections of health records will be scheduled with my therapist or the Site Clinical Director. I will be charged according to the Fee Agreement for professional time used to prepare the records for review and the time used to present them (the review may be incorporated into a therapy session if applicable and appropriate). The clinic cannot make a profit but can recover the cost of honoring your request.
   - I will be charged, according to the Fee Agreement, for a copy of my health record or a summary letter.
   - Payment, in full, is required before the requested information will be released to me.

_____ _____
Signature of Client or Legal Representative Date

_____
Printed Name of Client or Legal Representative

□ **Request Approved** Client #: _____
   - To ***inspect*** your health record.
   - To ***receive a copy of your health record***.
   - To ***receive a summary letter of the specified health information***.
   - Fee (must be paid in advance) _____.

□ **Request Denied** due to the following: _____
_____

□ This denial is not-reviewable.

□ This denial is reviewable. If you wish to have it reviewed, you must submit your request in writing to our Patient Rights Specialist at the address below. You will not be retaliated against in any way for requesting a review.

Kathleen Hayes, Patient Rights Specialist
710 N Webb Ave
Reedsburg, WI 53959
P = 608-524-5151

Clinician: _____ _____ Date: _____
(*Please print)* *(Signature)*