UNITED COUNSELING SERVICE

UCS

BUILDING A STRONGER COMMUNITY

Request for Access to Individual's Designated Record Set

I, _____ born on this date _____
Client name *Client's date of birth*

request access to my health information in the UCS designated record set. Specifically, I'm requesting

- ☐ an inspection, in whole or in part; or
- ☐ a copy, in whole or in part; or
- ☐ inspection and copy, in whole or in part.

Specific information I would like: _____

_____

UCS can offer you a paper and/or electronic copy of your records. Please read each option before selecting.

☐ Paper Copy – please indicate how you'd like to obtain the paper copy.

- ☐ U.S. Mail at the following address: _____
- ☐ Fax at the following number: _____
- ☐ I will pick-up the records from the front desk on Ledge Hill.

☐ Electronic Copy – please indicate how you'd like to obtain the electronic copy.

- ☐ E-mail; address: _____
- ☐ CD
- ☐ Flash Drive

Please provide us with the best phone number to reach you: _____

You have a right to direct us to deliver your health care records to another person. Please note that if your health information contains *substance use (drug or alcohol)* information you are required to fill out and sign an Authorization to Disclose PHI.

Name of the person: _____

☐ Paper Copy – please indicate how you'd like to obtain the paper copy.

- ☐ U.S. Mail at the following address: _____
- ☐ Fax at the following number: _____
- ☐ I will pick-up the records from the front desk on Ledge Hill.

☐ Electronic Copy – please indicate how you'd like to obtain the electronic copy.

- ☐ E-mail; address: _____

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☐ CD

☐ Flash Drive

- I understand that I have the right of access to inspect and obtain a copy of my protected health information maintained in the United Counseling Service designated record set for as long as the protected health information is maintained.
- I understand UCS has 30 days to fulfill my Request.
- I understand I may be denied access in whole or in part to the designated record set and that in certain circumstances I will not be provided a reason for denial.

I have read all the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

_____ _____

Name of Patient (please print) Date

_____ _____

Signature of Patient or Parent/Guardian Date

INTERNAL USE ONLY

Chart Number:_____ Clinician:_____

Date (Access granted by – 30 days from date of request):_____

☐ Request Provided

☐ Request Denied – In Whole

☐ Request Denied – In Part (Reviewable grounds documentation must be attached to this form.)

_____ _____

Authorizing Signature Title Date

Brief Description for Reason of Denial:

_____

_____

Date Individual was informed of decision:_____