Attachment A

Request To Access or Receive a Copy of Protected Health Information

I understand that I have the right to inspect or receive a copy of my protected health information. I understand that there may be a fee for copies and mailings and that I will be informed of the fee in advance. I understand that my request to access my records may be subject to some legal limitations and/or limitations established by a licensed healthcare professional to assure my health and safety and the safety of others. I also understand that CMU will respond to this request in less than 30 days unless I receive notification in writing that it will take longer to fulfill my request.

Client/Patient/Employee Name: _____ Date: _____
(Please Print Clearly.)
Address: _____ Telephone: _____
_____
_____

1. _____ I wish to inspect the records identified below during regular business hours at CMU.

2. _____ I would like a copy of the records identified below.

   _____ Copy to be mailed to (name, address, telephone number).
   _____
   _____
   _____
   _____

   _____ Copy to be picked up at time and place designated by CMU.

3. Identify the items from the records you wish to review.

_____ Time Period if Known
_____ From: _____ To: _____
_____
_____
(Please use additional pages if necessary.)

_____ _____
Client/Patient/Employee Signature Date

_____
Guardian Signature, if appropriate

_____
Relationship to Client

Revised as of 4/10/03

Attachment A

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(For office use only)

___ Request Denied ___ Approved as Requested ___ Approved Per Comments

Comments: ____

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Privacy Officer Signature: ___________________________________ Review Date: _____________________

PO Job Title: ________________________

Client Informed in Writing: Yes ___ Contact Date: _____________________

(Attach a copy to the C/P/E's file.)

Revised as of 4/10/03