SHEPHERD STAFF CHRISTIAN COUNSELING CENTER

Client Access to the Medical Record Request Form

INSPECT

I, ___________________________________, request access to my medical records for my personal inspection or by ___________________________________, my personal representative. I am interested in inspecting (specify "entire record" or the specific parts of the record you are interested in): ___________________________________
____
____

(Please suggest days of the week and times available for record access)
Day of the week__________________ Time_____________________________
Day of the week__________________ Time_____________________________
Day of the week__________________ Time_____________________________
Day of the week__________________ Time_____________________________
Day of the week__________________ Time_____________________________

OR
COPY

I, ___________________________________, request Shepherd's Staff Christian Counseling Center make a copy of my medical records for my personal inspection. I understand that these records contain protected health information (PHI). I am wanting a copy of (specify "entire record" or the specific parts of the record you are interested in):
____
____

I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be $15.00 plus 50 cents per page. I agree to pay this fee.

Patient Signature ________________________________ Date of Request ___________
Patient Printed Name and Date of Birth _______________________________________

Date received by Privacy Officer __________ Signature _________________________