

***Records Access Request***

**Date of Request:**       **A VALID, SIGNED RELEASE OF INFORMATION MUST BE INCLUDED WITH THIS REQUEST.**

|  |  |
| --- | --- |
| ***Client Name (last, first, middle):*** | ***DOB:*** |
| ***Previous/Maiden Name or Alias:*** | ***SSN:*** |
| ***Name of person making request (if different) and relationship:*** | ***Phone number to reach you:*** |
| ***Current address of requesting person (record will be sent to this address):*** | |

**Information Requested:**

|  |  |  |
| --- | --- | --- |
| DAF/Assessment  Individual Service Plan  Diagnosis  Progress Notes | Attendance/Service Record  Medication Summary  Psychiatric Records  Psychological Evaluation | Treatment Summary  HIV/AIDS Record  Drug/Alcohol Treatment Record  Reproductive Health Record |
| Other (Specify): | | |

**Date Requested (From/To):**       -      . **I wish to:**  **View Record**  **Receive a Copy of the Record**

I have a right to access this record because:

I am the client  I am the legal guardian of the client (must provide proof of legal guardian/representative.

I have provided a current authorization to release information signed by the client/parent/guardian.

I have been given information about chart request/coping fees. I understand Waybridge Counseling may take up to 15 business days from receiving my request to making a determination regarding my request and arranging access to the records, or longer if an extension is needed. I will receive written notice if my request is denied, explaining the reason for the denial.

Signature of Requestor

|  |
| --- |
| For Waybridge Counseling Office Use Only: |
| Verified ROI on file, and the specific information requested is authorized by the ROI. |
| Approved  Arrangements (dates, location, times, etc.): |
| Denied  Information was not specific on the ROI.  Knowledge of the healthcare information could reasonably be expected to cause substantial harm or cause danger for someone’s safety (requires explanation in chart and notice to requestor).  Other (requires explanation in chart and notice to requestor). |
| Licensed Professional Reviewer’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



***Copy Fee Agreement***

|  |  |
| --- | --- |
| ***Client Name (last, first, middle):*** | ***This is not a release of information. A valid, signed release must accompany this request.*** |

**Waybridge Counseling charges a reasonable fee for**

**preparation and copying of health information and reports.**

|  |  |  |
| --- | --- | --- |
| ***DESCRIPTION*** | ***AMOUNT*** | ***TOTAL*** |
| DIGITAL RECORDS | $20.00 |  |
| PRINTED COPIES-(Flat rate fee) | $35.00 |  |
| ***Total:*** |  |  |

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**Payment**

Credit Card-(A card processing fee of 3.5% +.30).

Card Number:

Expiration Date:

Security Code:

Zip Code :

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Invoice

Name:

Street:

City:

State:

ZIP:

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**FAX the following to 513-725-2410**

1. Records Access Request
2. Copy Fee Agreement
3. Authorization for Release of Information

**Authorization for Release of Confidential Information**

**Waybridge Counseling Services, 4030 Mt. Carmel Tobasco Road, Suite 102, Cincinnati, Ohio 45255**

**513-488-7161**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(please PRINT full name), hereby authorize

Waybridge Counseling Services, to:

**[ ] Release information to: [ ] Request information from:**

**Agency/Facility/Individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAX/PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specific information to be released to the above named individual or agency:**

|  |  |  |
| --- | --- | --- |
| [ ] DAF/Assessment Report | [ ] Attendance/Service Record | [ ] Treatment Summary/Recommendations |
| [ ] Individual Service Plan | [ ] Medication Summary | [ ] HIV/AIDS record |
| [ ] Diagnosis | [ ] Psychiatric Records | [ ] Drug/Alcohol Treatment Record |
| [ ] Progress Notes | [ ] Psychological Evaluation | [ ] Reproductive Health Record |
| [ ] Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Specific information to be released to Waybridge Counseling Services:**

|  |  |  |
| --- | --- | --- |
| [ ] DAF/Assessment Report | [ ] Educational Record | [ ] Treatment Summary/Recommendations |
| [ ] Individual Service Plan | [ ] Medication Summary | [ ] HIV/AIDS record |
| [ ] Diagnosis | [ ] Psychiatric Records | [ ] Drug/Alcohol Treatment Record |
| [ ] Progress Notes | [ ] Psychological Evaluation | [ ] Reproductive Health Record |
| [ ] Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Treatment Purposes:**

[ ] Assessment [ ] Treatment Planning [ ] Case Management [ ] Collaboration/Coordination of Services

[ ] Other:

**Expiration: (please select one of the following):**

[ ] This authorization expires 6 months or less from today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(expiration date).

[ ] This authorization expires in excess of 6 months from today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(expiration date).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian Signature Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Person Facilitating Request Staff Title Date