SUMMITSTONE
HEALTH PARTNERS

Request for Access to Protected Health Information (PHI)

www.summitstonehealth.org

______________________	______________________	____________
Client's name (please print)	**Client's Date of Birth**	**Client ID**

Form of PHI Requested:

_____ **Medical record** or _____ **Other** ______________________________

Timeframe of Information Requested:

Date(s) of service: ____

SummitStone Health Partners (SHP) will approve or deny this request within 30 days of its receipt of this properly completed form. SHP may extend this 30-day time period, if needed, and you will be notified if that is the case. SHP requires the authorized individual requesting PHI, to show photo I.D. upon receiving information requested. Therapy Progress Notes may contain sensitive health information and may required a meeting with a therapist prior to releasing.

I choose the following method of access to the medical record:

_____ Arrange a date, time and location to inspect the record.

_____ Have copies of the record made available to me, and I agree to pay copying charges, which are not to exceed $18.53 for the first ten pages or fewer, $.85 per page for pages 11-40, and $.57 per page for every additional page. If mailed to me, I agree to pay the additional cost of postage.

_____ To receive only electronic copies, and I agree to pay the flat fee of $6.50.

______________________________ ______________

Signature of client or client's legal guardian **Date**

______________________________ ______________

If not client, print name *Relationship to client*

Mailing Address: ______________________ Phone: ______________

______________________ *Okay to leave voicemail?* ______

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