Phillips Mental Health Counseling PC
Email: Lynda@Phillipscounselingpc.com
website: www.Phillipsmentalhealthcounselingpc.com

Phillips Mental Health Counseling, P.C

Form # 6 REQUEST TO INSPECT OR OBTAIN A COPY OF THE CLINICAL RECORD

Client's LAST NAME: _____. FIRST_____. M.I.____.
CASE #_____.

INSTRUCTIONS:

This form must be completed and returned to your therapist to inspect or obtain a copy of your mental health record. Information will be made available to you within 30 days from the date of this request.

DISCLOSURE WITH PATIENT'S CONSENT:

EXTENT OR NATURE OF INFORMATION TO BE INSPECTED/OBTAINED:

PURPOSE OR NEED FOR INFORMATION:

ADDRESS TO SEND REQUESTED INFORMATION:

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING INFORMATION:

FROM:

Phillips Mental Health Counseling PC
Email: Lynda@Phillipscounselingpc.com
website: www.Phillipsmentalhealthcounselingpc.com

I, _____the undersigned, have requested in writing that the above information, from my medical record, be made available to me. I understand that for me to obtain this information, I must submit this written request, and that the information will be provided to me within 30 days of this appeal.

I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to another party is forbidden without additional written authorization on my part.

NOTE: YOU WILL BE CHARGED A FEE FOR THE COPYING OF MATERIAL.

The fee is 75 cents per page.

Signature of Patient, or Signature of Parent/legal representative, (when required)
_____.

(Print Name of Patient) (Print Name of Parent/Legal representative)
_____.

(Date) Facility Action:

___Request approved.

___Request Denied. Reason for denial
_____

_____ Lynda Phillips, LCMHC. DATE: _____.

Revised -8/2021.