AURORA MENTAL HEALTH CENTER

1290 Chambers Road • Aurora, CO 80011 • Ph 303.617.2336 Fx 303.617.2445

REQUEST FOR CLIENT ACCESS TO PROTECTED HEALTH INFORMATION

I am requesting access to the protected health information of:

_____	_____	_____	_____
Client Name (please print)	Social Security Number	Date of Birth	AuMHC CID

The information to be disclosed includes the following checked documentation:

___ Medication History ___ Psychiatric / Psychological Evaluations ___ Progress Notes
___ Service Plans ___ Lab Studies ___ Discharge Summaries
___ Complete Record

Dates include: ___ Last 6 months ___ Last year ___ All Dates ___ Other: From_____To_____

The purpose for the Release is: Disclosure of information directly to the client or legal representative per their request.

I choose the following method of access to my protected health information:

_____ C**opies of the record** (There is no charge for the first copy of records in a 12-month period.)
_____ **Review the record** onsite at Aurora Mental Health Center. I understand that I must arrange a date and time with my therapist to review the record.
_____ **Written summary of the record** (I understand there will be a charge for a written summary of my record.)

This request will expire on _____ (date), or, if left blank, two years from the date of my signature.

_____	_____
Signature of Client or Legal Representative	Date
_____	_____
Please print name of Legal Representative	Phone
_____	_____
Street Address	City, State, Zip Code

If you are not the client, please identify your authority to act on the client's behalf by circling one of the following:

Parent of Minor / Guardian / Custodian / GAL / CASA / MDPOA / Personal Representative of Estate

I UNDERSTAND THAT, if access is denied, I have a right to a review by a licensed health care professional who is designated by Aurora Mental Health Center to act as a reviewing official and who did not participate in the original decision to deny access to the record.

For Center Use Only

Request Granted: ___ Clinician Signature: _____ Date: _____

Request Denied: ___ Date *Notice of Denial* mailed to Requester: _____

Supervisor Signature: _____ Date: _____

Records copied by (please initial) _____ Number of pages _____ Date copied _____

Documents reviewed by (signature) _____ Date_____

Records sent (date) _____ via: Mail Fax Picked Up