child
&family
DEVELOPMENT

PINEVILLE
11940 Carolina Pl Pkwy, #200, Pineville, NC 28134
p 704.541.9080 | f 704.542.0699

MIDTOWN
4012 Park Road, #200, Charlotte, NC 28209
p 704.332.4834 | f 704.372.9653

Client Access to Medical Record Request Form

Client's Name: ____ **Date of Birth:** ________________
(first name last name) **(mm/dd/yy)**
o Self or Printed name of client's representative: ____
Phone: ____________________________ **Relationship of representative:** _________________________________

I request copies of the above named client's medical record, as described below. I understand these records contain Protected Health Information (PHI). I understand this request form must be fully completed and signed in addition identification must be verified in order to process this request. I agree to be responsible for the cost of providing these records, as described and selected below.

DATES OF SERVICE: From ________________ **(mm/dd/yy)** to ________________**(mm/dd/yy)**

REQUESTED DOCUMENTS:
o List specific document(s): ____
o I request evaluations, treatment plans and progress notes.
o I request the entire medical record including daily notes, outside records, and signed forms or documents.

SELECT WHICH RECORDS YOU ARE REQUESTING:

o Occupational Therapy records
o Physical Therapy records
o Speech Therapy records
o Educational records
o Psychological records

RECORDS PRODUCTION (select the applicable option): Child & Family Development adheres to the HIPAA Privacy Rule 45 CFR 164.524: Individuals Rights under HIPAA to Access their Health Information which permits fees for electronic and paper copies of medical records. Payment is due prior to disbursement of records.

o **Electronic copies: $6.50 PROVIDE PERSONAL EMAIL:** X ____
o **Paper copies: Fee will be calculated based on pages printed (Minimum $10.00 fee)**

X____
Signature of client or client's representative Date

INTERNAL USE: CHILD & FAMILY DEVELOPMENT HIPAA OFFICER ACTION/COMMENTS
We will respond within 30 business days of the date of this request. **Employee Initials/Date:** ___________/______

- o Request approved without change
- o Part of this request approved with a change: ____
- o Request denied, in part or whole, for the following reason(s). The reasons listed below may not be appealed:
  - □ The information is not part of your designated record set □ The information contains psychotherapy notes □ Other:
- o We request a 30-day extension to respond due to: ____
- o Client notified. Date/Initials/Comments: ____
- o Additional comments ____

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Signature of HIPAA Privacy Officer or designee **Date**