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:

○ Occupational Therapy records
○ Physical Therapy records
○ Speech Therapy records
○ Educational records
○ Psychological records
○ ABA 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

o We request a 30-day extension to respond due to: _____
o Client notified. Date/Initials/Comments: _____
o Additional comments _____

_____
Signature of HIPAA Privacy Officer or designee Date

_____ _____