SHEPHERD STAFF CHRISTIAN COUNSELING CENTER

Client Access to the Medical Record Request Form

INSPECT

I, _____, request access to my medical records for my personal inspection or by _____, my personal representative. I am interested in inspecting (specify "entire record" or the specific parts of the record you are interested in): _____
_____
_____

(Please suggest days of the week and times available for record access)
Day of the week_____ Time_____
Day of the week_____ Time_____
Day of the week_____ Time_____
Day of the week_____ Time_____
Day of the week_____ Time_____

OR
COPY

I, _____, request Shepherd's Staff Christian Counseling Center make a copy of my medical records for my personal inspection. I understand that these records contain protected health information (PHI). I am wanting a copy of (specify "entire record" or the specific parts of the record you are interested in):
_____
_____
I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be $15.00 plus 50 cents per page. I agree to pay this fee.

Patient Signature _____ Date of Request _____
Patient Printed Name and Date of Birth _____

Date received by Privacy Officer _____ Signature _____