***Records Access Request***

**Date of Request:**       **A VALID, SIGNED RELEASE OF INFORMATION MUST BE INCLUDED WITH THIS REQUEST.**

|  |  |
| --- | --- |
| ***Client Name (last, first, middle):***      | ***DOB:***      |
| ***Previous/Maiden Name or Alias:***      | ***SSN:***      |
| ***Name of person making request (if different) and relationship:***      | ***Phone number to reach you:***      |
| ***Current address of requesting person (record will be sent to this address):***      |

**Information Requested:**

|  |  |  |
| --- | --- | --- |
| [ ]  DAF/Assessment[ ]  Individual Service Plan[ ]  Diagnosis[ ]  Progress Notes | [ ]  Attendance/Service Record[ ]  Medication Summary[ ]  Psychiatric Records[ ]  Psychological Evaluation | [ ]  Treatment Summary[ ]  HIV/AIDS Record[ ]  Drug/Alcohol Treatment Record[ ]  Reproductive Health Record |
| [ ]  Other (Specify):       |

**Date Requested (From/To):**       -      . **I wish to:** [ ]  **View Record** [ ]  **Receive a Copy of the Record**

I have a right to access this record because:

[ ]  I am the client [ ]  I am the legal guardian of the client (must provide proof of legal guardian/representative.

[ ]  I have provided a current authorization to release information signed by the client/parent/guardian.

I have been given information about chart request/coping fees. I understand Waybridge Counseling may take up to 15 business days from receiving my request to making a determination regarding my request and arranging access to the records, or longer if an extension is needed. I will receive written notice if my request is denied, explaining the reason for the denial.

Signature of Requestor

|  |
| --- |
| For Waybridge Counseling Office Use Only: |
| [ ]  Verified ROI on file, and the specific information requested is authorized by the ROI. |
| [ ]  ApprovedArrangements (dates, location, times, etc.):       |
| [ ]  Denied [ ]  Information was not specific on the ROI. [ ]  Knowledge of the healthcare information could reasonably be expected to cause substantial harm or cause danger for someone’s safety (requires explanation in chart and notice to requestor). [ ]  Other (requires explanation in chart and notice to requestor). |
| Licensed Professional Reviewer’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***Copy Fee Agreement***

|  |  |
| --- | --- |
| ***Client Name (last, first, middle):***      | ***This is not a release of information. A valid, signed release must accompany this request.*** |

**Waybridge Counseling charges a reasonable fee for**

**preparation and copying of health information and reports.**

|  |  |  |
| --- | --- | --- |
| ***DESCRIPTION*** | ***AMOUNT*** | ***TOTAL*** |
| [ ]  DIGITAL RECORDS | $20.00 |       |
| [ ]  PRINTED COPIES-(Flat rate fee) | $35.00 |       |
| ***Total:*** |  |       |

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**Payment**

[ ]  Credit Card-(A card processing fee of 3.5% +.30).

Card Number:

Expiration Date:

Security Code:

Zip Code :

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[ ]  Invoice

Name:

Street:

City:

State:

ZIP:

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**FAX the following to 513-725-2410**

1. Records Access Request
2. Copy Fee Agreement
3. Authorization for Release of Information

**Authorization for Release of Confidential Information**

**Waybridge Counseling Services, 4030 Mt. Carmel Tobasco Road, Suite 102, Cincinnati, Ohio 45255**

**513-488-7161**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(please PRINT full name), hereby authorize

Waybridge Counseling Services, to:

 **[ ] Release information to: [ ] Request information from:**

**Agency/Facility/Individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAX/PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specific information to be released to the above named individual or agency:**

|  |  |  |
| --- | --- | --- |
| [ ] DAF/Assessment Report | [ ] Attendance/Service Record | [ ] Treatment Summary/Recommendations |
| [ ] Individual Service Plan | [ ] Medication Summary | [ ] HIV/AIDS record |
| [ ] Diagnosis | [ ] Psychiatric Records | [ ] Drug/Alcohol Treatment Record |
| [ ] Progress Notes | [ ] Psychological Evaluation | [ ] Reproductive Health Record |
| [ ] Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Specific information to be released to Waybridge Counseling Services:**

|  |  |  |
| --- | --- | --- |
| [ ] DAF/Assessment Report | [ ] Educational Record | [ ] Treatment Summary/Recommendations |
| [ ] Individual Service Plan  | [ ] Medication Summary | [ ] HIV/AIDS record |
| [ ] Diagnosis | [ ] Psychiatric Records | [ ] Drug/Alcohol Treatment Record |
| [ ] Progress Notes | [ ] Psychological Evaluation | [ ] Reproductive Health Record |
| [ ] Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Treatment Purposes:**

[ ] Assessment [ ] Treatment Planning [ ] Case Management [ ] Collaboration/Coordination of Services

[ ] Other:

**Expiration: (please select one of the following):**

[ ] This authorization expires 6 months or less from today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(expiration date).

[ ] This authorization expires in excess of 6 months from today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(expiration date).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian Signature Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Person Facilitating Request Staff Title Date