REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

COMMUNITY REACH CENTER

TIER: _____ **MRN:** _____

CONSUMER INFORMATION

Name: _____ **Date of birth** (MM/DD/YYYY): _____

Phone number: _____ **Last 4-digit SSN** (optional): _____

RECIPIENT INFORMATION

☐ **Release to self** ☐ **Release to third-party**

Name (Company/Organization/Person): _____

Relationship to Consumer: _____

Phone Number: _____

METHOD OF ACCESS/DELIVERY

☐ **Email** **Email Address:** _____

☐ **Fax** **Fax Number:** _____

☐ **Mail** **Mailing Address:** _____

_____

☐ **In person pick-up**

☐ Brighton Office:
☐ Broomfield Office:
☐ Commerce City Office:
☐ DCMB Office:
☐ Early Childhood Services:
☐ Northglenn Office:
☐ Thornton Office:
☐ Westminster Office:

☐ **Arrange a date, time and location to inspect medical records chart.**

INFORMATION TO BE RELEASED

Information to be released, exchanged, and shared (Please check next to the documents to be released & exchanged).

☐ **The Medical Record, OR** ☐ **Other** (Specify): _____

DATES OF SERVICE ASSOCIATED WITH THE REQUEST

☐ **Current Episode of Care, OR** ☐ **Start Date:** _____ **End Date:** _____

- *Medical records may include confidential information related to drug and/or alcohol treatment, which is protected by federal law 42 CFR, Part 2, and/or HIV treatment.*
- *A FEE MAY BE CHARGED TO COVER THE COST OF PRODUCING THE RECORDS.*
- *Community Reach Center is not responsible for unauthorized access to the Protected Health Information (PHI) contained in electronic format or any risks (e.g., virus) potentially introduced to your computer/device when receiving electronic files.*
- *All updated legal custodianship/guardianship documentation must be provided prior to release of records.*
- *There must be a valid Release of Information (ROI) on file at Community Reach Center if records are being sent to a third party.*
- *Before access to a mental health record is granted or denied in some cases, the Center may request that a physician who practices psychiatry and is an independent third party review the record and consult with Center staff. I hereby grant permission for such a review.*
- *The Center will approve or deny this request within **30 days** of its receipt of this properly completed form. The Center may extend this 30-day time period, if needed, and you will be notified if that is the case.*
- *Records will remain available for in person pickup at select location for 45 days after confirmation of processing.*

_____ *Initial* **I have read the above and voluntarily authorize the disclosure of the protected health information as stated.**

_____ _____

Consumer or Authorized Representative **Date**

_____

Print Name

_____ *Initial* **I attest that I have legal guardianship of the above Consumer and/or have authority to obtain their treatment records.**

Submit form and associated documents to Medical Records Department via fax at 303-287-2477 or emailed to CRCMedRecords@communityreachcenter.org