

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION



CREDIBLE: _____ 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: DCMB Office:
 Thornton Office: Early Childhood Services:
 Westminster Office Northglenn 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.

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

Consumer or Authorized Representative

Date

Print Name

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

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