Beyond Counseling Center LLC

Request to Access Protected Health Information Form

Client Name: _____ **Parent/Guardian Name:** _____

Address: _____

Phone Number: _____ **Client DOB:** _____

Are you requesting to take a copy of these records with you? ☐ **Yes** ☐ **No**

There is no fee for the first copy requested. There is a $25 fee for any additional copies requested within 1 year of the original request.

****Please note: I have up to 30 days to process your request. Please indicate below if you need your request by a specific date.****

Please specify the protected health information you would like to access:

☐ **Clinical Assessment** ☐ **Progress Notes** ☐ **Other-Please Specify Below:** _____

☐ **Psychological Evaluation** ☐ **Letter** _____

If you requested a letter, what information would you like included in the letter?

_____

_____

_____

Please explain why you would like to access your protected health information:

_____

_____

_____

Please indicate a time that would be convenient for you to meet with us regarding your request.

_____

_____ _____

Client Signature **Date** **Print Client Name**

_____ _____

Authorized Representative **Date** **Print Representative Name**

_____

Relationship of Authorized Representative