DIRECTORS APPROVAL: _____

Didi Hirsch
MENTAL HEALTH SERVICES

CLIENT'S REQUEST
TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

I understand that Didi Hirsch may deny this request under limited circumstances as provided for under federal and California law protecting the privacy of health information. I further understand that, except as permitted under the law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Didi Hirsch who did not participate in the agency's decision to deny my request.

I understand that Didi Hirsch MHS will notify me of its decision to approve or deny access within five (5) working days of their receiving my written request. I understand that if my request for information is approved, a copy will be made available to me within ten (10) working days of approval.

I understand that if I request a summary of my health information, I will be able to inspect or obtain a copy of the summary within ten (10) working days from the date of receipt of my request. If Didi Hirsch needs additional time to prepare the summary because of the length of the record or because the client was discharged from Didi Hirsch within ten (10) days prior to receipt of my request, I will be notified and the agency may have up to thirty (30) days from the date of receipt of my request to make the summary available to me.

Please provide us with the following information so that we can best serve you.

Name: _____
First, **Last** **Middle Initial**

Phone No. **Hm: ( )** _____ **Cell: ( )** _____ **Date of Birth:** _____

Are you currently a client: ☐Yes ☐No

If yes, _____
Name of Assigned Therapist/Care Coordinator

INFORMATION TO BE REQUESTED: (check all that apply)

- ☐ Assessment (s)
- ☐ Clinical Progress Notes
- ☐ Medical Progress Notes
- ☐ Attendance Information
- ☐ Summary of Services: including- admission/discharge dates, service location, service type, services provided, diagnosis)
- ☐ Medications (names and dosages)
- ☐ Other (Specify): _____

I am only interested in the following time period:_____/_____/_____through_____/_____/_____.

PURPOSE FOR YOUR REQUEST:
In our efforts to safely maintain your records and provide you with the information needed, please state purpose for your request:

_____

_____

_____

_____

DIRECTORS APPROVAL: _____

Didi Hirsch
MENTAL HEALTH SERVICES

I would prefer to: ☐ **Pick up** (If picking up, please have your photo ID available) **Or** ☐ **Have the requested summary mailed to me at the following address** (Note: This is your address – not a third party address):

⇨

Signature of Client / Legal Representative **Date**

Printed name

If signed by someone other than the client, state relationship to the client:

Staff / Witness Signature/ title **Date**

This Authorization was translated into_____for the client/legal representative.

Client was provided a copy of this Request For Records ☐Yes ☐No ☐Declined