REQUEST FOR CLIENT ACCESS TO RECORDS

Name of Client: _____

Client ID and/or DOB: _____

Please specifically describe your Protected Health Information (PHI) that you would like to access:

- ☐ Clinical/Medical Record: please specify _____
  _____
- ☐ Billing Record: please specify _____
  _____
- ☐ Other: please specify _____
  _____

I would like (please check one):

- ☐ A copy of the PHI
- ☐ To review or inspect the PHI
- ☐ A summary of the PHI

Other – please describe: _____
_____
_____

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I understand that if I request a copy of my PHI that there will be a charge for the copy and for the costs of mailing. The Home will charge a flat fee of $20.00 for copying, labor and mailing.

_____ _____
Signature of Client, Guardian or Other Authorized Representative *Date of Request*

_____ _____
Please print name *Phone number(s)*

_____ _____
Mailing address *State, Zip Code*

I_____, a Notary Public for _____County, and _____, State, do hereby certify that _____personally appeared before me, and proved his/her identification through satisfactory evidence, which were_____ and acknowledged the due execution of this Request.

Witness my hand and official seal, this _____ day of _____, 2017.

My commission expires_____, 20___.

_____
(Official Seal) Notary Public

Please submit form to:

The Home for Little Wanderers
Health Information Department
780 American Legion Highway
Roslindale, MA 02131
Tel: 617-469-8673 Fax: 617-469-8350