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: _____
_____

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. The fee is waived for current clients.

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

_____
Please print name

_____
Mailing address

_____
Mailing address

_____
Phone number(s)

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 _____, 2018.

My commission expires_____, 20___.

_____
(Official Seal) Notary Public

Please submit form to:

Health Information Manager`
780 American Legion Highway
Roslindale, MA 02131
Tel: 617-469-8673
Fax: 617-469-8350