



REQUEST TO ACCESS A RECORD

For use when a client or their representative makes a request to view or copy the clinical record.

Date of Request:		DOB:	
Client Name: <i>(last, first, middle)</i>		SSN:	
Previous / Maiden Name or Alias:		Phone Number to Reach You:	
Name of requestor (if different):		Relationship:	
Current Address of requesting person:			

Information Requested:

<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Intake Evaluation <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Medications	<input type="checkbox"/> Medical Diagnosis <input type="checkbox"/> Medical History <input type="checkbox"/> Progress Notes <input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Psychological Evaluations <input type="checkbox"/> School <input type="checkbox"/> Treatment Plan <input type="checkbox"/> History of Services <i>(may include billing information)</i> <input type="checkbox"/> Other:
---	---	--

Dates Requested: from: _____ to: _____. I wish to: View Record Copy Record

I have the right to access this information because:

- I am the client I am the legal guardian of the client (must provide proof of legal guardian/representative)
 I have provided a current Authorization to Release Information signed by the client/parent/legal guardian.

I have been given information about copying fees. I understand Compass Health may take up to 15 business days from receiving my request to make a determination regarding my request and arrange access to my records, or longer if an extension is needed. I will receive written notice if my request is denied, explaining the reasons for the denial.

Signature of Client / Guardian / Other

FOR OFFICE USE ONLY:	
<input type="checkbox"/> Verified ROI on file, and the specific information requested is authorized by the ROI (if client/representative is not the requesting party.)	
<input type="checkbox"/> Approved Arrangements (dates, location, time, etc.):	
<input type="checkbox"/> Denied – ANY redaction constitutes a denial. <input type="checkbox"/> Information was not specified on ROI (if client/representative is _____ not requesting party.) <input type="checkbox"/> Knowledge of the healthcare information could reasonably be expected to cause danger to someone’s life or safety or cause them substantial harm (requires explanation.) <input type="checkbox"/> Other (requires explanation.) *If client/guardian/representative was requester, they must be sent a letter. Sample available on SharePoint form 254a.	Explanation of denial:
Licensed Professional Reviewer Name <i>(please print)</i> :	
Reviewer Signature:	



COPY FEE AGREEMENT

Client Name/ID/DOB (or affix label):	<i>This is not a release of information. A valid, signed release must be obtained prior to estimate being given, if requestor is someone other than client or legal guardian.</i>
---	---

Compass Health may charge a reasonable fee for providing health care information and is not required to permit examination or copying until the fee is paid (RCW 70.02.080(2)). Most requests will include a charge for the preparation and copying of the information and and/or reports.

The current fees for copying information are as listed: <i>(per WAC 246-08-400)</i>	
\$28.00 Clerical/Machine Fee PLUS \$1.24 per page – first 30 pages	\$0.94 per page – after 30 pages PLUS Tax
If records requested exist in an electronic format are sent and received in a digital format, there will be a \$6.50 fee plus tax (instead of per page copy fees)	

NO FEE will be charged for providing basic information to another health care provider. This is a common courtesy provided for continuity of care. The provider must be listed on the release form to have the charge exempted.

NO FEE will be charged for client/guardian requests for the Transition Summary, a Treatment Summary, or any request 10 pages or less. If the information you request is over 10 pages, there will be charges as indicated above. Individuals appealing the denial of federal supplemental security income or social security disability benefits may receive one free copy of their health care information. Individuals that have been denied client portal access will receive records free of charge.

I would like to receive my records via Encrypted USB Encrypted E-mail Paper copies of my records

Estimated cost: Please note this is only an estimate based on an assumption of the number of copies to be made. When this request is processed, you WILL be charged for the actual number of pages copied.

- Unable to determine estimate at this time. If you would like to be notified of the approximate amount due before we copy your records, please indicate below and add your contact information.
- Yes, I would like to be notified of the approximate amount due.
- Estimated number of copies: _____.

Contact Information: Phone #: _____ **E-Mail:** _____

Description	Cost	Total
Existing Digital Records – USB-Email	\$ 6.50	
Copies – clerical fee	\$28.00	
+ per page copy – first 30 pages	\$1.24	
+ per page copy – after 30 pages	\$.94	
SUBTOTAL		
TOTAL OF ESTIMATE*		

*Applicable tax will be calculated and billed by the Medical Records Department when generating the final invoice.

Requestor Signature: _____
 Staff Signature: _____

OFFICE USE ONLY: Complete only if ESTIMATE was unable to be given prior to signature and there was a request for an estimate to be given by phone.		
_____ (informant name) was called on _____ (date) and has accepted the approximate fee	of \$ _____	Initials: _____ Date: _____