Peace of Mind Counseling
Melissa Earls, LPC

Patient Access to the Medical Record Request Form

I, _____, request access to my medical records for my personal inspection or by _____, my personal representative. (Please request date and time requested for record access)

Date_____ Time_____

OR

I, _____, request Melissa Earls, LPC make copies of my medical records for my personal inspection. I understand that these records contain protected health information (PHI). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be $1.00 per page* and I will be charged a minimum of $15.00. I agree to pay for this prior to the service being rendered.

Patient Signature/Parent Guardian if Minor Child _____

Patient Printed Name and Date of Birth _____

Date of request _____

Practice Response to Request (Must be within 60 days of receipt of request.)

__ Grants all or part of your request_____
__ Denies all or part of your request_____
_____

For the following reason: (Circle all that apply)

Not part of your designated record set; contains psychotherapy notes; information was compiled for civil, criminal or administrative actions; subject to CLIA; regards inmate at correctional institution; was created during research; is subject to Federal privacy act; was not created by this practice.

Patient may not appeal if denial is for any of the above reasons

__ Denied at the discretion of the practice as the information may be harmful to the patient or a third party

__ Requests a 30-day extension to respond due to _____

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