Access Solutions Behavioral Health

Request for an Individual's Health Information

Last:_____ First:_____ Middle:_____

Other Name Used:_____ Date of Birth:_____

Address:_____ City:_____ State/Zip:_____

Home Phone:_____ Cell:_____

☐ I hereby request access to the protected health information in my health record from (date) _____ to (date)_____ maintained or created by the following providers associated with the medical clinic listed below.

☐ Most recent progress note ☐ Entire Health Record

☐ Pathology/Lab results ☐ Other: _____

☐ Imaging Reports ☐ Billing Records

☐ I WILL PICK UP THE COPIES OF MY RECORDS ☐ FAX ☐ MAIL COPIES OF MY RECORDS TO THE INDIVIDUAL NOTED BELOW

[ ] TO: [ ] FROM:	[ ] TO: [ ] FROM:
NAME:	ACCESS SOLUTIONS BEHAVIORAL HEALTH
ADDRESS:	4750 S GARNETT RD SUITE B
CITY/STATE/ZIP:	TULSA, OK 74146
PHONE: FAX:	PH: 539-812-2100 FAX: 800-242-5174

PURPOSE OF REQUEST: ☐ Patient's Request ☐ Dispute ☐ Referral ☐ Provider

I UNDERSTAND:

I may revoke this authorization al any time by providing my written revocation to Access Solutions Behavioral Health, 4750 S. Garnett Rd, Ste B, Tulsa, OK 74046, My revocation will not apply to Information already retained, used, or disclosed In repose to this authorization.

Unless the purpose of this authorization is to determine payment of a claim or benefits, Access Providers may not alter t he condition or the provision of treatment or payment for my care on my signing this authorization.

Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations,

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

The health Information authorized for release also may Include protected health information related to mental health.

The Information authorized for release also may include drug/alcohol abuse treatment records. This category of medical Information/records is protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit anyone receiving this Information or records from making further release unless further release Is expre ssly permitted by the written authorization of the person to whom It pertains or otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other Information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally Investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

X:_____

Signature of Patient/Parent/Legally Authorized Representative Relationship to Patient Date