Center for Human Development

ACCESS REQUEST FORM

Patient's Name:	____________	____________	____________
	Last	First	Middle
Home Address:	____________________________________		
	____________________________________		
Home Phone:	____________________	**Date of Birth:** ____________________	

I hereby request that CHD provide me with **[please check all boxes that apply]** ☐ access to **OR** ☐ my own copy of the "Requested Information" checked below:

- ☐ My medical records.
- ☐ My billing records.
- ☐ Any other personally identifiable information used by CHD to make medical decisions about me.

[Please also check one of the three boxes below:]

- ☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period ________ through ___________.
- ☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by CHD at a cost to me of $5.00 for the first 5 pages and $.10 for each additional page not to exceed $22.50.
- ☐ I would prefer to receive the Requested Information in the form of a summary prepared by CHD at a cost to me of the current hourly rate defined in the CHD rate schedule for the staff preparing the report.

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or other information limited or restricted by applicable law.

I understand that CHD may deny this request under limited circumstances as provided for under federal and Oregon law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the CHD who did not participate in the CHD's decision to deny my request.

I understand that CHD will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within five (5) days of receiving this request. .

Please provide the Requested Information to me in **[please check the appropriate boxes]** ☐ electronic form (on a disc) **OR** ☐ paper form. I would prefer to: ☐ pick-up or view the Requested Information at a mutually agreeable time and place; **OR** ☐ have the Requested Information mailed to me at the following address:

____
____
____

I understand that CHD will charge me $5.00 for the first 5 pages and $.10 for each additional page not to exceed $22.50 for the copying services necessary to complete my request, as well as any applicable mailing fees. If I am granted access to the Requested Information, I **[please check the appropriate box]** ☐ would ☐ would not like CHD to provide me with an additional written explanation of such Requested Information at an additional cost to me of the current hourly rate defined in the CHD rate schedule for the staff preparing the report.

____ ____________________
Signature of Patient (or Personal Representative) Date

____ ____________________
Printed name of Personal Representative Date

____
Relationship of Personal Representative to Patient

* * * * *

After you have completed this form please return it to the Privacy Office by mail or by facsimile at the following address: Privacy Office, CHD, 2301 Cove Ave, La Grande, Oregon, 97850 (Facsimile: (541) 963-5272).