*(For use by clients or participants requesting access to their own records.)*

***Include any special instructions determined by the organization itself or state law.***

|  |  |
| --- | --- |
| Name: | ID Number: |
| Record Holder: | Date of Birth: |
| Location of Record: | Date of Request: |

If you are asking for access to records that this organization has, please consider the following:

* You may ask to access, look at or get information about yourself that is in the organization’s records.
* The organization cannot give you access to psychotherapy notes.
* The organization may deny you access to your information if someone other than a health care provider gave it to the organization under the promise of confidentiality.

I am asking for access to my information for the following time period:

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(See other side for information on client or participant rights)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Approved | | | |  | | |
| Denied | | | |  | | |
| Delayed | | | |  | | |
|  | | | | | | |
| If Delayed, we will act on your request by | | | | | |  |
| Comments: | |  | | | | |
|  |  | |  | | | | |
|  |  | | | | | |
|  |  | | | |  | |
|  |  | | | | | |
|  | Organization Representative Signature Date | | | | | |

**Your Rights to Access Your Information:**

* You have a right to request access, look at or get information about yourself that is in organization records.
* You have a right to have an answer to your request within 30 days. If the information is not at this location, you have the right to have an answer within 60 days. If there are delays in getting you the answer, you will be told. The delay cannot be more than 30 days. You will receive an answer in writing.
* You may be charged a fee if you have accessed the same information within the past year.
* Your request may be denied if professionals involved in your case believe that access to your information could be harmful to you or others.
* The reviewer must decide, within a reasonable time, whether to approve or deny your request. You will get an answer in writing. The answer will include the reason for the decision.

*You have a right to file a privacy complaint:*

Individuals can file privacy complaints with either the organization or with the U.S. Department of Health and Human Services, Office for Civil Rights.

Privacy complaints may be directed to any of the following:

## Organization Name

### Name of person to be contacted within organization

Organization Address

### Phone Number

Fax Number

Email Address

## U.S. Department of Health and Human Services, Office for Civil Rights

Medical Privacy, Complaint Division

200 Independence Avenue, SW

# HHH Building, Room 509H

Washington, D.C. 20201

### Phone: 866-627-7748

TTY: 886-788-4989   
Email: www.hhs.gov/ocr