202 N. 8th Street, El Centro CA 92243

ACCESS TO RECORDS REQUEST FORM

Completion of this form gives you the opportunity to request access to see and obtain a copy of your records, with some limitations.

Patient Information

Name:	Date of Birth:
Address:	
Phone:	Email:

Request for Access

I am requesting to:

- ☐ Inspect my records.
- ☐ Receive a summary of my records.
- ☐ Pick up a hardcopy of my records.
- ☐ Receive a hardcopy of my records. by mail
- ☐ Other: ______________________
- ☐ Receive my records via encrypted Email.
- ☐ Receive my records via encrypted email*

**Sending information by unencrypted email increases the risk of it being read by an unauthorized third party. By signing this form below, you acknowledge the risks associated with unencrypted email.*

Note: In the event ICBHS approves your request to inspect your record, you may be contacted by an ICBHS representative to arrange an appointment prior to receiving a written response.

I am requesting access to the following records:

Mental Health:
☐ Assessment(s) ☐ Care Plan ☐ Problem List ☐ Progress Notes
☐ Discharge Summary ☐ Medications ☐ Diagnosis ☐ Attendance
☐ Other: ______________________

Substance Use Disorders:
☐ Assessment(s) ☐ Treatment Plan ☐ Problem List ☐ Progress Notes
☐ Discharge Summary ☐ Medications ☐ Diagnosis ☐ Attendance
☐ Drug Screening Results ☐ HIV Test Results ☐ TB Test Results
☐ Other: ______________________

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

From: ______________________ To: ______________________

Signature

______________________ ______________________
Signature of Client/Personal Representative* Date

*If signed by someone other than the client, print name and specify relationship to the client:

______________________ ______________________
Name Relationship

ICBHS Response – PLEASE DO NOT WRITE BELOW THIS LINE	
☐ Approved	If you requested to inspect your records, an appointment is scheduled for: Date: Time:
☐ Denied	See attached letter.
☐ Delayed	Your request is delayed because: We will act on your request by:
Comments:	

____________________ Clinician Signature

____________________ Clinician Printed Name

__________ Date

ADVISEMENT

Your Right to Access Your Information:

- You have a right to inspect or receive copies of information about yourself that is in ICBHS records.
- You must provide your request in writing to inspect or receive copies.
- You have a right to inspect your record during business hours within 5 working days after ICBHS receives your written request.
- If you request copies, you have the right to receive them within 15 working days of ICBHS receiving your written request. You may be charged a reasonable cost-based fee.
- Your request may be denied if professionals involved in your case believe that access to your information could be harmful to you or others.
- You may be denied access to your information if the information was given to ICBHS by someone other than a health care provider, under the promise of confidentiality.
- 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.

NOTICE OF RIGHTS AND OTHER INFORAMTION

For more information about your privacy rights, see the Notice of Privacy Practice posted in all our lobbies and buildings.

If you believe your privacy rights have been violated, you may file a complaint with Imperial County Behavioral Health Services (ICBHS) or with U.S. Department of Health and Human Services, Office for Civil Rights. All Privacy complaints must be submitted in writing. You will not be penalized for filing a complaint.

Privacy complaints may be directed to:

ICBHS Privacy Officer
202 N. 8th Street
El Centro, CA 92243
Phone: (442) 265-1525
Fax: (442) 265-1583
Email: icbhsprivacyofficer@co.imperial.ca.us

Or

U.S. Department of Health and Human Services,
Office for Civil Rights
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov