CLIENT ACCESS TO RECORDS

Client Name:____Birth Date:_______________________
Address:____City/State/ZIP Code:_________________
Phone Number(s):____SS#:_____________________________

If Records are to be released to an individual other than yourself, please provide the recipients information:

Release Information to: ***(leave blank if same as above)***

Name of Person: ______________________________Relationship to client _________ Phone Number: _____________
Address: ____City/State/ZIP Code: _______________________________

I request a copy of my medical record as detailed below:

☐ Biopsychosocial Assessment ☐ Lab Reports ☐ Screening Information ☐ Other (must specify) ________________
____
☐ Medication List ☐ Treatment Plans ☐ Physical Examination
☐ Diagnosis ☐ Safety Plan ☐ Progress Notes
☐ Discharge Summary ☐ Office Visit ☐ Intervention Tx. Notes

Reason I am requesting copies of the record (***optional***):____

Please choose one of the following:

☐ ***Red Rock BHS has a standard procedure to release records in electronic form, on a password protected thumb drive, at zero cost. I agree to receive my records electronically.***
☐ ***I choose to have documents printed, at a cost of .25 per page up to $150 cap. I understand I must pay for the printed document before it will be released to me.***

How would you like your medical records to be delivered? ☐ Mailed ☐ Picked Up ☐ Secure Email ☐ Thumb Drive

Information that is not subject to one of the reasons for denial listed below will be provided to you as requested.

_____________________________________ _______________________________ ____________
Signature of Patient or Legal Representative Relationship Date

---

THIS SECTION FOR RED ROCK BEHAVIORAL HEALTH SERVICES USE ONLY

Date request received by Healthcare Practitioner:____________________ Approved____ Denied____
If Request is denied, check reason for denial, (as allowed in 45 CFR 164.524 (a)(2)(3) and Okla. § 43A-1-109-B):

_______ Endangerment - A licensed health care professional has determined that the access requested is reasonably likely to endanger the life or physical safety of the client or another person. The client may request a review of a denial for this reason.

_______ Reference to other people - The information requested makes reference to another person and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person. The client may request a review of a denial for this reason.

_______ Personal Representative - A licensed health care professional has determined that the provision of access to the information requested is reasonably likely to cause substantial harm to the individual (personal representative), or another person. The client may request a review of a denial for this reason.

_______ Information from Other Source - The information requested was obtained from someone under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

_______ Inmate Information - Releasing a copy of the requested records would jeopardize the health, safety, security, or rehabilitation of the client or of other inmates, or the safety of any officer, employee, or other person at the correctional institution, or who is responsible for the client's transportation.

_______ Legal Information - All, or a portion of, the information requested has been compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

_______ Information Not Available - We do not have the information requested. The information requested can be obtained from:____________________________. (Alternative location will be indicated, if known).

Name of Healthcare Practitioner (Please print):____________________________ Title:____________________________

Signature of Healthcare Practitioner:____________________________________ Date:____________________________

Comments:____

If you do not agree with the decision, you may request a review of the decision by contacting the Director of Medical Records, Kelsie Shay, kshay@red-rock.com, or 405-425-0429. A complaint may be submitted to Red Rock Behavioral Health Services' Corporate Compliance Officer, Katherine Harris, via email to kaharris@red-rock.com or telephone 405-419-3046; or the HHS Office for Civil Rights, Oklahoma's region: Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202
Customer Response Center: (800) 368-1019, Fax: (202) 619-3818, TDD: (800) 537-7697 Email: ocrmail@hhs.gov Chart #: ___________