HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

CLIENT REQUEST TO ACCESS RECORDS

PLEASE READ CAREFULLY AND COMPLETE

Date: ____________________________ Client Name: ____

Client's Date of Birth: ______________

This request applies to the clinical record created by Henrico Area Mental Health and Developmental Services (HAMHDS) and other records used by HAMHDS to make decisions about the above named client. These records are called the "designated record set"

Request access to:

☐	Obtain written summary of treatment
☐	View above named client's "designated record set"
☐	Obtain copies of the above named client's designated record set pertaining to:
☐	Obtain a copy of the above named client's entire designated record set

Copies of the records will be furnished for a fee. $0.50 per page up to 50 pages and $0.25 a page thereafter for copies from paper or other hard copy generated from electronic storage, plus all postage and shipping costs and a $10.00 search and handling fee.

____ ______________________

Signature of Client Date

_____ **Initials of HAMHDS staff who verified client identity**

If different from Client,
Name of Person Requesting Access: (Print) ______________________________________

Phone #: _______________________

Address: ____

Relationship to Client is:

☐ Legal Guardian

☐ Authorized Representative

☐ Other:

____ ______________________

Signature of Legally Authorized Representative Date

_____ **Initials of HAMHDS staff who verified relationship documentation**

Response to Request to Exercise Individual Rights Letter (REC470) completed within 15 days of request.