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: ☐Psychological Evaluation ☐Medication List ☐Diagnosis ☐Initial Assessment ☐Psychiatric Evaluation ☐Psychiatric Progress Notes ☐Discharge Summary Other:
☐	Obtain a copy of the above named client's entire designated record set

What format do you prefer:

☐	Paper
☐	Electronic (cd) available for records maintained in electronic format

Copies of records will be furnished for a fee: $0.37 per page up to 50 pages and $0.18 a page thereafter for copies from paper or other hard copy generated from electronic storage; $5.00 per cd for an electronic copy generated from electronic storage. A $10.00 fee for search, handling and postage will be assessed for all requests.

How would you like the records delivered:

☐	By Mail. Address:
☐	In-Person Pickup

_____ _____

Signature of Client Date

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

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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 30 days of request.