REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

Please submit this request to: medicalrecords@summitstonehealth.org

Client's Name (Please Print): _____ **Client's DOB:** _____ **Client MRN:** _____

Please indicate what PHI/medical record information is being requested:

☐ Diagnosis	☐ Attendance Dates/Scheduling	☐ Intake	☐ Treatment Plan(s)
☐ Medications	☐ Lab Reports/VA-BA Results	☐ Demographics	☐ Housing/Employment Notes
☐ Psychiatric Evaluation	☐ Psychiatric Progress Notes	☐ Discharge Summary	☐ Therapy Progress Notes*

**These notes may contain sensitive health information and may require a meeting with therapist prior to release.*

☐ **Other:** _____

_____

Date(s) of service: _____ to _____

SummitStone Health Partners ("SummitStone") will approve or deny this request within 30 days of receiving this properly completed form. If needed, SummitStone may extend this 30-day time period and you will receive notification. SummitStone requires the authorized individual requesting PHI, to show photo I.D. upon receiving information requested. Therapy Progress Notes may contain sensitive health information and may require a meeting with a therapist prior to releasing.

I choose the following method of access to the medical record:

☐ To receive only electronic copies on a flash drive

☐ To receive only electronic copies via Encrypted Email. **A copy of your photo ID is required at the time of request.**

- Email Address: _____
- Copy of photo ID Included in request ☐ Yes ☐ No

For paper copies, please reach out to Medical Records at Medicalrecords@summitstonehealth.org or 970.494.9760

_____ _____

Signature of Client or Client's Legal Guardian | Date

_____ _____

If not Client, Print Name | Relationship to Client

Mailing Address: | Phone Number:

_____ _____

_____ *Okay to leave voicemail?* _____

_____