REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

COMMUNITY REACH CENTER

Nextgen MRN: _____

CONSUMER INFORMATION

Name: _____ Date of birth (MM/DD/YYYY): _____

Phone number: _____ Last 4-digit SSN (optional): _____

RECIPIENT INFORMATION

☐ Release to self ☐ Release to third-party

Name (Company/Organization/Person): _____

Relationship to Consumer: _____

Phone Number: _____

METHOD OF ACCESS/DELIVERY

☐ Email Email Address: _____

☐ Fax Fax Number: _____

☐ Mail Mailing Address: _____

☐ In person pick-up

☐ Brighton Office: ☐ DCMB Office:

☐ Thornton Office: ☐ Early Childhood Services:

☐ Westminster Office ☐ Northglenn Office:

☐ Arrange a date, time and location to inspect medical records chart.

INFORMATION TO BE RELEASED

Information to be released, exchanged, and shared (Please check next to the documents to be released & exchanged).

☐ The Medical Record, OR ☐ Other (Specify): _____

DATES OF SERVICE ASSOCIATED WITH THE REQUEST

☐ Current Episode of Care, OR ☐ Start Date: _____ End Date: _____

- *Medical records may include confidential information related to drug and/or alcohol treatment, which is protected by federal law 42 CFR, Part 2, and/or HIV treatment.*
- ***A FEE MAY BE CHARGED TO COVER THE COST OF PRODUCING THE RECORDS.***
- *Community Reach Center is not responsible for unauthorized access to the Protected Health Information (PHI) contained in electronic format or any risks (e.g., virus) potentially introduced to your computer/device when receiving electronic files.*
- *All updated legal custodianship/guardianship documentation must be provided prior to release of records.*
- *There must be a valid Release of Information (ROI) on file at Community Reach Center if records are being sent to a third party.*
- *Before access to a mental health record is granted or denied in some cases, the Center may request that a physician who practices psychiatry and is an independent third party review the record and consult with Center staff. I hereby grant permission for such a review.*
- *The Center will approve or deny this request within **30 days** of its receipt of this properly completed form. The Center may extend this 30-day time period, if needed, and you will be notified if that is the case.*
- *Records will remain available for in person pickup at select location for 45 days after confirmation of processing.*

_____ **I have read the above and voluntarily authorize the disclosure of the protected health information as stated.**
Initial

_____ _____
Consumer or Authorized Representative Date

_____
Print Name

_____ **I attest that I have legal guardianship of the above Consumer and/or have authority to obtain their treatment records.**
Initial

Submit form and associated documents to Medical Records Department via fax at 303-287-2477 or emailed to CRCMedRecords@communityreachcenter.org

Updated: 6/24