CMS Client ID: _____ Client Insurance ID: _____

CLIENT REQUEST FOR TREATMENT RECORDS

Use this form each time a client requests to receive a copy of any portion of their treatment record

Client Name	

Request for Client Treatment Records	
I request to receive a copy of my treatment records from _____ to _____	
…in the following record set(s)	☐ Counseling notes ☐ Medical notes, including medical provider and nursing notes ☐ Laboratory screens, including drug screening ☐ Intake information, including assessments ☐ Enrollment, payment, insurance claims information maintained by CMS ☐ Other records: _____
…in the following way	☐ Pick up at the clinic ☐ By mail (enter address below):

I understand there is specific health information to which this agency may deny access, as follows:

- Psychotherapy (counseling) notes where the information contained would be detrimental to the client or another individual if released
- Information compiled for legal proceedings
- Information created or obtained in ongoing research that includes treatment if this was a condition of participation in the research

I further understand under circumstances when a licensed health care professional denied my request for access to my health information that I can request a review by another licensed health care professional.

Client Signature	
Date	

Review of Request

This section is for clinic use only

❑ **DETERMINATION: REQUEST APPROVED**	❑ **DETERMINATION: REQUEST DENIED**		
Provide the records requested on page one via the method requested.	**Reason for Denial:** ❑ The access requested is reasonably likely to endanger the life or physical safety of the individual or another person ❑ The PHI refers to another person and the access requested is reasonably likely to cause substantial harm to such other person ❑ Access requested by personal representative and access cause substantial harm to client or other(s) ❑ Other _____		
	CMS Responsibilities: ❑ Written notice to client of basis for denial ❑ Provide client with opportunity to request review by licensed health care professional in agency		
Clinical Coordinator Signature		**Date**	
Person Providing Records		**Date**	

If the request is denied and the client requests a secondary review, complete the information below:

❑ **2nd DETERMINATION: DENIAL OVERTURNED**	❑ **2nd DETERMINATION: DENIAL UPHELD**		
Provide the records requested on page one via the method requested.	**Reason for Denial:** ❑ The access requested is reasonably likely to endanger the life or physical safety of the individual or another person ❑ The PHI refers to another person and the access requested is reasonably likely to cause substantial harm to such other person ❑ Access requested by personal representative and access cause substantial harm to client or other(s) ❑ Other _____		
	CMS Responsibilities: ❑ Written notice to client of basis for denial ❑ Provide client with information about client rights in the state		
Medical Provider Signature		**Date**	
Person Providing Records		**Date**	