



Access to Records Request

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), clients have a right to request the opportunity to inspect and copy their health information. This right to access does not pertain to information compiled in anticipation of or use in a civil, criminal or administrative action, to information received in confidence from an individual other than the health care provider, psychotherapy notes or if there is a belief that access to the information could be harmful to the client or others. We will evaluate each request and make a determination. A fee may be charged if a client has received access to the same information within the previous 12 months.

I hereby request access to health information for:

Name:	ID Number:
Address:	Date of Birth:
Record Holder:	Date of Request:

For Office Use Only:

- Approved Denied
 Delayed, we will act on this request by _____

Comments: _____

WDH Representative Signature: _____
Documentation of Relationship:
 Reviewed Attached

Scope of Access Requested

- I would like access to: All the records **or**
 The portion of the records concerning:

I understand information may include information related to the treatment of behavioral, mental health, drug, alcohol or sexually transmittable diseases.
(Specify type of disease, accident, dates of treatment or other portion of records of interest.)

Type of Access Requested

- Inspection.** Please let me know when and where I may inspect my records and the fee, if any. I understand that an employee of Wyoming Department of Health may be present and I may not mark or alter the record in any way.
 Copies. I would like copies of the records requested.
 I would like the information in the following format: _____

Charges

Inspection: I understand I may be charged a reasonable fee for clerical costs incurred in making records available for inspection.
Copies of Transfer: I understand a reasonable fee may be charged for copies.

- I hereby agree to pay all charges specified above. Please contact me with the total cost I will incur.

Signed: _____ **Print Name:** _____ **Telephone:** _____ **Date:** _____

If not signed by the patient, please indicate the relationship:

- Guardian or conservator of an incompetent client
 Parent or guardian of minor client
 Beneficiary or personal representative of deceased client
 Other (specify) _____

Name of Client: _____