Headquarters: 251 Llewellyn Avenue, Campbell, CA 95008
Phone (408)379-3790 Fax (408)364-4013 www.upliftfs.org

Esta forma está disponible en Español

Customer ID#:_______________Admit:______________
Name:____
DOB:________________
Program:______________________________________
County ID:_____________________________________

Complete or place Customer ID Label
· Staff Only ·

CUSTOMER RIGHT TO REQUEST ACCESS TO HEALTH RECORD

Please complete this form if you are requesting to view or receive copies of the health record maintained by Uplift Family Services for the individual listed below. This is not to be used as a HIPAA Authorization.

The undersigned customer or customer's legal representative hereby requests access to the Health Records of:

____ _____/_____/_____ ◯ Adult ◯ Minor [1]
CUSTOMER NAME DATE OF BIRTH

Facility/Regional Location(s) for which I am requesting records: ____

Where do you want the information sent? (Fill in boxes below):

Uplift Family Services should provide my records to: ◯ Self ◯ Personal Representative ◯ Other

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

I am requesting records be delivered in the following manner: (select ONE circle and check appropriate choice of delivery)
◯ Electronic copies – E-mail ………> _____ Encrypted or _____ Unencrypted (method is unsecure & may pose a risk of disclosure)
◯ Electronic copies – CD …………..> _____ Mail OR _____ Pick Up
◯ Paper copies ……………………….> _____ Mail OR _____ Pick Up OR _____ FAX (up to 10 pages only)

What records do you want? (Check appropriate circles below):

Dates of Service: ______/______/______ through ______/______/______

◯ Medical ◯ Mental Health [2] ◯ Substance (Drug/Alcohol) Abuse [2] ◯ HIV test results ◯ Billing Records

After choosing the category of records listed above, please check the types of records you want below:

_____ Diagnosis(es) _____ Medication list _____ Results of Psychological/Psychiatric tests
_____ Discharge Summary _____ Assessment Information _____ Summary of Treatment
_____ Lab test results _____ Other: ____

[1] I understand that if I am a parent/legal guardian making a request regarding records of a minor, I will not be shown entries for health care to which, by law, the minor may consent without parental involvement. I understand that if I am a minor, I will be given access only to those portions of my record describing health care for which I may consent, under applicable law, without the involvement of parents.
[2] I understand that records of mental health care or substance (drug/alcohol) abuse treatment may not be disclosed to me directly if the health care provider determines that to do so would present a risk of significant adverse or detrimental consequences. I understand that the provider may provide me with a summary of the requested records instead of copying or providing the original records for examination. I understand I then may designate a physician, licensed psychologist, or clinical social worker to review the record on my behalf.

Please print your name and sign below:

Name of Customer or Personal Representative (please print)	Relationship (please print)	
		_____ Initial OK to leave message
Signature of Customer or Personal Representative	Date/Time	Phone:

Return completed form to your local clinic office or mail to the corporate address above.
Original/Chart Copy/Customer