Anchorage Community Mental Health Services 4020 Folker Street Anchorage, AK 99509
Fairbanks Community Mental Health Services 1423 Peger Road Fairbanks, AK 99709

Request for Access to or Copies of Electronic or Paper Records

Client Information: _____ Record number: _____
(Last) (First)
Date of Birth: _____ Phone: _____

Address: _____
(Street) (City/State) (Zip)

Email Address: _____

____ **I am the Guardian of the above named client**. Name: _____
My contact phone: _____ Guardianship appointment date: _____

I'm requesting access to my records or copies of my records for the following reason(s):

_____Continuing Care
_____Insurance
_____Legal
_____Other (please explain):
_____Personal Use
_____Billing

ACCESS REQUEST: If approved, access to your record means that a staff member would sit with you to review the Designated Record Set (documents use for decision making) in your paper and/or electronic chart.

Please specify treatment dates: _____

Discharge Summary _____
Psychiatric Evaluation _____
Intake Assessment _____
Medication Records _____
Treatment Plans_____
Medical Progress Notes_____
Clinical Notes _____
Lab Results _____

COPY REQUEST: If approved allows you to get a hard copy set of documents from the Designated Record Set in your chart, or an electronic copy if it is possible to get the document in an electronic form.
Please provide my records in the indicated format:

Paper Records: _____

Electronic Records*: (USB or e-mail)*_____ *(client **must** register with the Company's secure messaging system to receive PHI via e-mail)*

Please specify treatment dates: _____

Discharge Summary _____
Psychiatric Evaluation _____
Intake Assessment _____
Medication Records _____
Treatment Plans_____
Medical Progress Notes_____
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I realize there is a cost associated with requesting my records in hard copy based on the number of pages I'm requesting. I will pay for the records in advance if I elect to have them mailed. Otherwise I will pay in full when I pick the records up.

For paper copies: First 5 pages no cost; 6–15 pages $5.00, each additional page is $.50.

For electronic records: 1-5 pages $15.00 flat fee, each additional page is $.25.

I acknowledge there is a cost associated with receiving a copy of my records based on the number of pages requested. (Please initial selection below)

_____ I agree to pay for a copy of my records in advance if I elect to have them mailed.
_____ I agree to pay for a copy of my records when I pick them up.

Please understand your records will be reviewed by a licensed healthcare professional and if, in their professional judgment, it is reasonably likely that access to and/or copies of your records will endanger the life or physical safety of the you, the client, or another person your request may be denied in full or in part. The decision to approve or deny the request will be made by the Privacy Officer or designee. If you are denied all or parts of your records you will receive a written determination explaining why your request has been denied. The written determination will be provided to you with a process for appeal.

_____ _____
Signature of person requesting records Date of requested

_____ _____
Print Name Relationship to client

To inquire about the status of your request you may call:

Clinical records: **ACMHS** 563-1000

Clinical records: **FCMHS** 371-1300

Once you have requested your records you will receive them within a 30-day period.

Records mailed: _____ Pick records up: _____