Crossroads Counseling Center, Inc.

Client Request for Access to Personal Protected Health Information

Instructions: *Please complete this form in its entirety and either mail or submit to your local CCC Office. Please print legibly.*

CLIENT INFORMATION: I request and authorize the release of personal health information related to:

Client Name: _____ _____

Street Address: _____

City, State, Zip: _____

Phone: _____ SSN (last 4 digits only) or Medicaid No.: _____

RELEASE INFORMATION FROM: *(Select CCC Office)*	☐ Harrisonburg Office, 250 E. Elizabeth St., Suite 102, Harrisonburg, VA 22802 ☐ Luray Office, 221 West Main Street, Luray, VA 22835 ☐ Manassas Office, 7547 Presidential Lane, Manassas, VA 20109 ☐ Winchester Office, 420 W. Jubal Early Dr. Suite 203, Winchester, VA 22601 ☐ Winchester Office, 174 Costello Dr. Winchester, VA 22602

REQUESTED INFORMATION (*Select all that apply):*

☐ Clinical Assessment(s) ☐ Service/Treatment Plan ☐ Monthly Summaries ☐ Quarterly Reviews
☐ Progress Notes ☐ Discharge Summary ☐ Entire Service Record
☐ Other (specify):

Please fill in the dates of treatment for the records to be released or accessed:

☐ Treatment dates FROM: _____ TO: _____ ☐ ALL Treatment Dates ☐ Most Recent Only

I authorize CCC to release or disclose the requested information to:

☐ Me as the client of record ☐ Me as the Parent/Legal Representative - Enter Name and contact information below.
☐ Other Individual/Organization – Enter Name and contact information below.

Name/Organization: _____ Relationship to client: _____

Street Address: _____

City, State, Zip: _____

Phone: FAX No.:

PURPOSE:	☐ Continuation of Care ☐ For Personal Use ☐ Insurance ☐ Attorney ☐ Other (specify):_____

DELIVERY METHOD:	☐ Please mail paper records to the *(select one)* ☐ Client Address or ☐ Other Address provided above. ☐ Fax to the number above. ☐ I will pick up the records. I request *(select one)* ☐ paper records (no fee) ☐ electronic records (fee may be imposed for electronic media). ☐ I wish to review the records (You will need to make an appointment to review).

I understand that this is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), HIV/AIDS, and other sexually transmitted diseases, unless indicated in the following instructions: _____.

I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

Signature of Client/Legal Representative: _____ Date: _____

If Parent/Legal Representative, Print Name: _____ Relationship to client:_____

To be completed upon receipt or review: I hereby acknowledge that I have received or reviewed the records as requested.

Signature of Client/Legal Representative: _____ Date: _____

For CCC Use Only

Staff Name Receiving Request: _____ Date Request Received: _____

Verification of evidence of Requester's authority to receive requested records:
☐ Driver License ☐ Other: _____

Mental Health Record Release Approval: *I have reviewed the service record to determine if it contains information that if released, would be reasonably likely to endanger the life or physical safety of the client or another person.*

☐ Request Approved ☐ Request Denied Date Approved/Denied: _____

Reason for denial (if applicable): _____
(Per VA Code §32.1-127.1:03.F requests may only be denied by a physician or clinical psychologist. Attach supporting documentation from physician or clinical psychologist to justify denial.)

Signature: _____ Date: _____

Printed Name: _____

Request Completed: *(Must be fulfilled within 15 days of receipt of the request or notification of need for extension is sent)*
Date request fulfilled (copies delivered/review complete): _____

Staff Name who fulfilled: _____

If Request denied, Date Requester notified in writing: _____

If Extension Required: *(Extension not to exceed an additional 30 days)*
Date Requester notified in writing of need for extension to fulfill request: _____
Extension deadline to respond to request (not to exceed total of 45 days from date of original request): _____