REQUEST FOR CONSUMER ACCESS TO PROTECTED HEALTH INFORMATION

Comsumer Name and Date of Birth: | Acct#:

Consumer Address (number, street name, city, state, zip): | SS#:

Please Specify the information requested:

Please Specify the format for the information requested(circle): (Paper) (Digital) (Fax)

I agree to accept a SUMMARY of the requested information (circle): (Yes) (No)

I agree to pay all costs associated with this request for access to Protected Health Information: (Yes) (No)

Please indicate the consumer, parent of a minor, or any legal guardian or personal representative who is requesting access to the information.

Individual's Name: | Relationship to Consumer:

SIGNATURE OF CONSUMER OR LEGAL REPRESENTATIVE | DATE

DO NOT WRITE BELOW THIS LINE- FOR DOGON MEDICAL GROUP USE ONLY!

Date Received: | Access has been: (Granted) (Denied)

Comments:

If denied, letter of denial provided to consumer on (date)_____

Reasons(s) for denial without right for review:	Reasons for denial WITH right for review:
O Psychotherapy Notes	O Reasonably likely to endanger life or physical safety of consumer or other person
O Patient agreed to denial of access while in research project	O Documentation makes reference to third party and granting access is likely to cause serious harm
O Information for use in civil, criminal, or administrative Proceedings	O Personal representative is requesting Party, and consumer has been or may be subject to domestic violence, abuse and/or neglect
O Information obtained from source other than SED under Promise of confidentiality and access would identify the Source	

NAME AND TITLE OF STAFF MEMBER PROCESSING REQUEST:

SIGNATURE OF HEALTH CARE PROVIDER: | DATE: