Compass Health

# *REQUEST TO ACCESS A RECORD*

**For use when a client or their representative makes a request to view or copy the clinical record.**

| | | | |
|---|---|---|---|
| ***Date of Request:*** | | ***DOB:*** | |
| ***Client Name**: (last, first, middle)* | | ***SSN:*** | |
| ***Previous / Maiden Name or Alias:*** | | ***Phone Number to Reach You:*** | |
| ***Name of requestor (if different):*** | | ***Relationship***: | |
| ***Current Address of requesting person:*** | | | |

**Information Requested:**

| | | |
|---|---|---|
| ☐ Discharge Summary (Free)<br>☐ Assessment<br>☐ In House Laboratory Results<br>☐ Medications | ☐ Letter to (_____)<br>☐ Treatment Summary (Free)<br>☐ Progress Notes<br>☐ Psychiatric Evaluations | ☐ Treatment Plan Reviews<br>☐ Crisis Plan<br>☐ Treatment Plan<br>☐ History of Services *(may include billing information)*<br>☐ Other: |

**Dates Requested:** from:_____ to:_____ I wish to: ☐ View Record ☐ Copy Record

I have the right to access this information because:

☐ I am the client ☐ I am the legal guardian of the client (must provide proof of legal guardian/representative)

☐ I have provided a current Authorization to Release Information signed by the client/parent/legal guardian.

I have been given information about copying fees. I understand Compass Health may take up to 15 business days from receiving my request to make a determination regarding my request and arrange access to my records, or longer if an extension is needed. I will receive written notice if my request is denied, explaining the reasons for the denial.

**Signature of Client / Guardian / Other**

| **FOR OFFICE USE ONLY:** | |
|---|---|
| ☐ Verified ROI on file, and the specific information requested is authorized by the ROI (if client/representative is not the requesting party.) | |
| ☐ Approved<br>Arrangements (dates, location, time, etc.): | |
| ☐ Denied – ANY redaction constitutes a denial.<br>☐ Information was not specified on ROI (if client/representative is not requesting party.)<br>☐ Knowledge of the healthcare information could reasonably be expected to cause danger to someone's life or safety or cause them substantial harm (requires explanation.)<br>☐ Other (requires explanation.)<br>*If client/guardian/representative was requester, they must be sent a letter. Sample available on SharePoint form 254a. | Explanation of denial: |
| Licensed Professional Reviewer Name *(please print)*: | |
| Reviewer Signature: | |

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# COPY FEE AGREEMENT

| ***Client Name/ID/DOB*** *(or affix label):* | *This is not a release of information. A valid, signed release must be obtained prior to estimate being given, if requestor is someone other than client or legal guardian.* |
|---|---|

Compass Health may charge a reasonable fee for providing health care information and is not required to permit examination or copying until the fee is paid (RCW 70.02.080(2)). Most requests will include a charge for the preparation and copying of the information and and/or reports.

The current fees for copying information are as listed: *(per WAC 246-08-400)*

\$28.00 Clerical/Machine Fee **PLUS**
\$1.24 per page – first 30 pages
\$0.94 per page – after 30 pages
**PLUS Tax**

**If records requested exist in an electronic format are sent and received in a digital format, there will be a \$6.50 fee plus tax (instead of per page copy fees)**

**NO FEE** will be charged for providing basic information to another health care provider. This is a common courtesy provided for continuity of care. The provider must be listed on the release form to have the charge exempted.

**NO FEE** will be charged for client/guardian requests for the Transition Summary, a Treatment Summary, or any request 10 pages or less. If the information you request is over 10 pages, there will be charges as indicated above. Individuals appealing the denial of federal supplemental security income or social security disability benefits may receive one free copy of their health care information. Individuals that have been denied client portal access will receive records free of charge.

I would like to receive my records via ☐ Encrypted USB ☐ Encrypted E-mail ☐ Paper copies of my records

**Estimated cost: Please note this is only an estimate based on an assumption of the number of copies to be made. When this request is processed, you WILL be charged for the actual number of pages copied.**

☐ Unable to determine estimate at this time. If you would like to be notified of the approximate amount due before we copy your records, please indicate below and add your contact information.

☐ Yes, I would like to be notified of the approximate amount due.

☐ Estimated number of copies: _____.

**Contact Information: Phone #:** _____ **E-Mail:** _____

| ***Description*** | ***Cost*** | ***Total*** |
|---|---|---|
| Existing Digital Records – USB-Email | \$ 6.50 | |
| Copies – clerical fee | \$28.00 | |
| + per page copy – first 30 pages | \$1.24 | |
| + per page copy – after 30 pages | \$.94 | |
| **SUBTOTAL** | | |
| **TOTAL OF ESTIMATE*** | | |

*Applicable tax will be calculated and billed by the Medical Records Department when generating the final invoice.

Requestor Signature: _____

Staff Signature: _____

***OFFICE USE ONLY:*** Complete only if ESTIMATE was unable to be given prior to signature and there was a request for an estimate to be given by phone.

_____ *(informant name)* was called on _____ *(date)* and has accepted the approximate fee of \$ _____. Initials: _____ Date: _____