Aspen COUNSELING & Consulting, L.L.C.

Request for Access to Inspect or Copy Record

Client Name: ______________________ Today's Date: ______________

Client ID: __________ DOB: __________ Phone #: ______________ Cell Phone #: ______________

Address: ____

Send Information to:

- ☐ Above address
- ☐ Name: ______________________________________

Address: ______________________________________

I am requesting the following:

☐ I wish to review my record as follows (indicate location and time): ______________________________

☐ I am requesting a copy of the following portion of my record. Requested Time Frame: ______________________

- ☐ Evaluations
- ☐ Progress Notes
- ☐ Toxicology Reports / Drug Screens
- ☐ Insurance Coverage / Financial Information
- ☐ II would like confirmation of treatment only.
- ☐ Other: ______________________________
- ☐ Discharge/Transfer Summary, Continuing Care Plan
- ☐ Medical Information/Medication
- ☐ Diagnosis
- ☐ Social Security Request

I understand there may be a fee associated for reproduction of the record of $__________. We must receive payment before we can release this information. (See back for fees).

I request my record in ☐ paper format or ☐ electronic format (fax/secure website upload).

I understand my request may be granted or denied. In either event, my request will be responded to in 30 days for on-site records or 60 days if the records are off-site, unless I am notified of an extension. I understand that if my request is denied, I am able to request a review of the denial.

______________________________________ ______________

Signature of Client Date

______________________________________ ______________

Signature of Parent/Guardian (if applicable) Date

**** There must be a valid Authorization for Release/Exchange of Confidential Information on file for the recipient of the information****

For Rosecrance Use Only:

Date Request Received: ______________________ Request Repsonse Due Date: ______________________

Confirmation of Client ID/Authorized Party:

☐ Client with ID (photo ID or EHR filed photo) ☐ Next of kin (on attorney letterhead) ☐ Executor letter (on letterhead)

☐ Other: ______________________________

30 day extension entacted: ☐ Yes ☐ No (If yes, new required response date: ______________________)

Action Taken (check one): ☐ Granted ☐ Denied (if denied state reason below)

Justification of denial:

☐ No proper ID ☐ No signed Authorization for Release ☐No proper court order/subpoena

☐ Other____

☐ Fee received: $______________

Staff person releasing record: ______________________ ______________________ ______________

Print name Signature Date

Charges for Client or Personal Representative				
Qty	**Information Stored**	**Information Sent**	**Unit Price/Fee Calculation**	**Total**
	Electronic PHI	Electronic Copy	$6.50 flat fee	
	Electronic PHI	Paper Copy	Labor: $1.20 Supplies: $.02 per page Postage:	
	Paper PHI	Electronic Copy	Labor: $.05 per page Supplies: CD or USB	
	Paper PHI	Paper Copy	Labor/Supplies: $.07 per page Postage:	
			Total:	

Charges for Third Party Access			
Qty	**Description**	**Unit Price**	**Cost**
	Handling Charge	$29.09	
	Copy pages 1 - 25	$1.09 per page	
	Copy pages 26 - 50	$.73 per page	
	Copy pages in excess of 50	$.36 per page	
Actual cost of postage:			
		Total:	

In Illinois, we may charge the handling fee but only 50% of the per-page fee above.

Please make check payable to:

Aspen Counseling & Consulting
8616 Northern Avenue
Rockford, IL 61107
FEIN # 36-4257786