Protected Health Information (PHI) Access Request Form

CLIENT INFORMATION

Full Legal Name: ____ Date of Birth: ___________________

Address: ____

Phone: _____________________________________ (Hm/Wk/Cell) Account ID Number: _____________

REQUEST FOR ACCESS

Requested PHI:

□ Diagnostic Assessment	□ Treatment Plan	□ Chemical Dependence Assessment
□ Progress Notes	□ Treatment Progress Summary	□ Discharge Summary
□ Appointment History	□ Billing Records	
□ Entire Health Record	□ Other: _________________	

□ Mental health treatment records dated from _________________ (date) to ________________(date)

PHI is requested for purposes of: ____

I hereby authorize Wild Tree Psychotherapy, LLC and its respective employees, agents and subcontractors, to disclose protected health information about the above-named client. This authorization applies only to fulfilling this request for access to PHI. Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations. I understand that reviewing of mental health records has the potential to cause emotional distress and is not guaranteed to aid in legal issues, personal insight or other related purposes.

Authorized Representative Signature: _______________________________________

Relationship to Client: ____________________________

Date: _________________________