**Access Request to Medical Records**

Client Name (Include Alias) _____ Date of Birth_____

Address:_____ City, State, Zip:_____

Phone Number:_____

Social Security Number_____ Approximate Date of Treatment _____

I hereby request that San Luis Obispo Behavioral Health provide access to the medical record of the client named above. request this access as (*check one*):

☐ Client

☐ Client of the minor patient

☐ Other_____*

☐ Guardian of the minor patient*

*Please furnish a copy of your appointment papers with this request.

***Purpose or need for information:*** _____

_____

***The type of access requested is (check one):***

☐ Inspection of the record

☐ A Summary of the record (Client request only)

☐ Copies of the record as follows (*check one*):

☐ Entire record

☐ Following portions of the record only (*specify*):_____

_____

Did the client request a printed copy of the record? □ Yes □ No

Did the client request an electronic copy of the record? □ Yes □ No

***Who May Sign:*** (after reasonable verification of identity of person claiming to be the patient or representative):

1. Adult Client.
2. Legal guardian or conservator of the person of the adult patient with copies of letters of conservatorship. Psychiatric conservatorships must be renewed annually.
3. Minor client (12-17) may sign and is entitled to access to his record which pertains to health care services.

Name _____
(Please Print)

Signature_____
(Client/Patient)
A minor client's signature (12-17) is required in order to release information concerning care for mental health conditions and/or alcohol drug abuse issues.

Phone No._____

Signature_____
(Parent/Guardian)
Conservator with copy of court papers/ letters of conservatorship.

Date_____

Leave Message on Phone Yes ☐ No ☐
Copy Given to Client Yes ☐ No ☐ Initials____