SOUTH CENTRAL HUMAN RELATIONS CENTER
Providing Direction for Life's Problems Since 1964

507-451-2630 Fax: 507-455-8133
610 Florence Avenue
Owatonna MN 55060

CLIENT'S ONE-TIME REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

You have the right to see and get a copy of your health records, either paper or electronic, and have your provider send a copy of your records to someone else within 30 days. If you request a second copy of the same information, we will charge you a reasonable fee for copying and mailing. If you request a Summary of your information, we will charge you for your providers' time to create the summary. If you are the Personal Representative of our client authorized by state law to act on their behalf, a copy of your legal authority (guardianship or custody order) must be provided to us. Any attempt to falsely gain access to protected health information is subject to legal penalties. We may deny your request if your licensed healthcare professional believes it could be harmful to you or to others. If denied, you have the right to have another licensed healthcare professional, who was not involved in the original review, review your request.

Client Name:____**D.O.B.:**____/___/____**Client #:**____________

Method to Access your Protected Health Information:

☐ **Pickup at this HRC location:** ____

☐ **eMail** To protect you, we send this encrypted by Zix and you will need to create a log in and password to open it. Sometimes these land in your junk mail. If you want us to send it unencrypted, please indicate your understanding that your information may be visible to others, is not secure and this is what you are requesting by initialing here: ☐

Email address to send to: ____

☐ **Mail** Street Address____________________________City_______________State_____Zip__________

☐ **I wish to review the requested information in person.** This requires that you schedule an appointment with one of your providers.

☐ **I request that my records be sent to a third party:** Name/Entity____

Method Address________________________________City_______________State_____Zip__________

Email: ______________________________ Encrypted: ☐ I understand the risk and request Unencrypted: ☐
(Please indicate your choice by initialing the box of your choice)

HIE: ______________________________ Fax: ______________________________

Information Requested: Date from/to or specific visit date:____

____Diagnostic Assessments ____Psychiatric Evaluation ____Testing results
____Progress Notes ____Psychological Reports ____Letter(s)
____Chemical Dependency Program
____Other (specify)____
____Instead of records, you may request a Summary. We will charge you to create this.
____Designated Record Set (this could be extremely large and require multiple mailings or e-mailings)

Signature and Identity Verification:

____ ______________________
Indicate if you are: Client, Parent, or Personal Representative (Legal proof provided if representative not parent) Date

____
Type of identity verification