PRAIRIE RIDGE ADDICTION TREATMENT SERVICES

CLIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Name of Client: _____ Date of Birth _____/_____/_____

Social Security Number: _____ Date of request _____/_____/_____

I request that Prairie Ridge provide me with access to my personal health information as indicated below:

Information Requested

☐ **Treatment Records** ☐ **Billing Records**

☐ **Other** _____

I request access to my personal health information covering the dates of ____/____/_____ through ____/____/_____.

Access Requested

☐ **Copies of requested information**
Please specify the format you desire

☐ Hard Copy: _____

☐ Other: _____

I understand that Prairie Ridge may charge a fee for the costs of copying, mailing or other supplies associated with my request and that access will be granted within 30 days of its receipt unless otherwise notified.

Please mail the information to: _____

_____

_____

☐ **Personal inspection of my health information at Prairie Ridge**

Please contact Prairie Ridge to arrange a mutually convenient time for inspection.
PO Box 1338, 320 North Eisenhower Avenue, Mason City, IA 50402;
Telephone: (641) 424-2391

_____ _____/_____/_____
Signature of Client Date

Office Use: ☐ **Request Granted**
☐ **Request Denied**

Reason for Denial:

_____

Client has the right to file a complaint with our office or to the Secretary of Health and Human Services (HHS).

Signature of Prairie Ridge Official: _____ **Date:** _____

Original-File, Copy-Client