

**WESTERN PSYCHOLOGICAL & COUNSELING SERVICES {WPCS}  
ACCESS REQUEST FORM**

<b>Patient's Name:</b>	_____		
	Last	First	Middle
<b>Home Address:</b>	_____ _____		
<b>Home Phone:</b>	_____	<b>Date of Birth:</b>	_____

<b>Provider Information:</b> {Please list all Western Psychological & Counseling Services providers/therapists/Medication Management providers you have seen starting with the most recent }	
Current Provider: _____	Date last seen: _____
Other Provider(s): _____ _____	

- I hereby request that WPCS provide me with **[please check all boxes that apply]**
- access to **OR**  my own copy of the "Requested Information" checked below:
- My medical records.
  - My billing records.
  - Any other personally identifiable information used by WPCS to make medical decisions about me.

**[Please also check one of the three boxes below:]**

- I am only interested in accessing or obtaining a copy of Requested Information relating to the time period \_\_\_\_\_ through \_\_\_\_\_.
- I am interested in accessing or obtaining a copy of all Requested Information maintained by WPCS.
- I would prefer to receive the Requested Information in the form of a summary prepared by WPCS at a cost to me of \$150.00/HR.

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or other information limited or restricted by applicable law.

I understand that WPCS may deny this request under limited circumstances as provided for under federal and Oregon law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the WPCS who did not participate in the WPCS's decision to deny my request.

I understand that WPCS will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within five (5) days of receiving this request if the information is maintained or accessible on-site at WPCS or within five (5) days if the Requested Information is not maintained or accessible on-site at WPCS.

Please provide the Requested Information to me in  paper form only. I would prefer to:  View the Requested Information at a mutually agreeable time and place; **OR**  have the Requested Information mailed to me at the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that WPCS may charge me **\$2.00** per page for the copying services necessary to complete my request, as well as any applicable mailing fees. If I am granted access to the Requested Information, I [**please check the appropriate box**]  would  would not like WPCS to provide me with an additional written explanation of such Requested Information at an additional cost to me of \$0.00.

\_\_\_\_\_  
Signature of Patient (or Personal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Personal Representative to Patient

\* \* \* \* \*

After you have completed this form please return it to the Privacy Office by mail or by facsimile at the following address:

C/O Privacy Office

PO Box 82819

Portland,, OR 97282

fax number (503) 233-2693