WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

Request to Access Your Record

Note: This form is to request copies of one's own records. To request to have records sent to a third party, complete an "Authorization to Disclose Protected Health Information"

Last Name: [ ] First: [ ]

Other Names used: [ ]

DOB: ______/______/__________ Phone:

How would you like to receive the records? : secure email option not available for all requests

Mailed (Certified) [ ] Address: ____________________

____

____

Pick up at Clinic [ ] Clinic location: ____________________

Secure email: [ ] Address: ____________________

DISCLAIMER: SECURE EMAIL NOT AVAILABLE FOR ALL DATES OF SERVICE AND RECORDS

Records Requested (check all that apply):

Packet (includes Assessment, Treatment plan, and Notes. No fees) [ ]

Full Record set (may include additional fees) [ ]

Other records wanted: [ ]

Specify: ____________________

____

____

Dates of Service:

Date From: _____/_____/__________ Date to: _____/_____/__________

All dates of service: [ ]

Provider(s):

Provider(s): ____________________

All Western Providers: [ ]

Patient/ Personal Representative

Signature: ____________________ Date: _____/_____/__________

If personal representative:

Print Name: ____________________

Relationship to client: Parent- [ ] Guardian- [ ]