SEQUOIA
MENTAL HEALTH SERVICES, INC.

ACCESS REQUEST FORM

Individual's Name:	______________________________ Last First Middle	
Address:	______________________________	
Phone:	__________________	**Date of Birth:** __________________
Requested Time Period	__________________ through __________________	

I hereby request that **Sequoia Mental Health Services, Inc.** provide me with access to the "Requested Information" checked below:

- ☐ My medical records.
- ☐ My billing records.
- ☐ Any other personally identifiable information used by **Sequoia Mental Health Services, Inc.** to make medical decisions about me.

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 **Sequoia Mental Health Services, Inc.** 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 **Sequoia Mental Health Services, Inc.** who did not participate in the **Sequoia Mental Health Services, Inc.**'s decision to deny my request.

I understand that **Sequoia Mental Health Services, Inc.** will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within **thirty (30)** days of receiving this request if the information is maintained or accessible on-site at **Sequoia Mental Health Services, Inc.** or within **sixty (60)** days if the Requested Information is not maintained or accessible on-site at **Sequoia Mental Health Services, Inc.**

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I would prefer to: ☐ pick-up the Requested Information at a mutually agreeable time and place;
OR ☐ have the Requested Information mailed to me at the following address:

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I understand that **Sequoia Mental Health Services, Inc.** may charge me **$.25 per page** for the copying services necessary to complete my request, as well as any applicable mailing fees.

______________________________ ______________
Signature of Patient (or Personal Representative) Date

______________________________ ______________
Printed name of Personal Representative Date

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Relationship of Personal Representative to Patient

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

Sequoia Mental Health Services, Inc.
4585 SW 185th Avenue
Aloha, OR 97007
(Fax: 503-848-2072)

This request has been ☐ APPROVED
This request has been ☐ DENIED for the following reasons:

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______________________________ ______________
Signature of Sequoia Staff Date

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Printed Name of Sequoia Staff