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 **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.**

I understand that records cannot be disclosed to anyone other than the individual whose information is being requested for those 14 year of age or older unless written consent is provided. Parents/Guardians for those under 18 years of age are not entitled to treatment information except if; It is clinically appropriate and, in the minors' best interests, the minor must be admitted to a detoxification program; or, the minor is at risk of committing suicide and requires hospital admission.

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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 securely emailed to me at the following email address:

_____

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

_____ _____
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 Officer with a copy of your ID 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:

_____
_____

_____ _____
Signature of Sequoia Staff Date

_____
Printed Name of Sequoia Staff