



## REQUEST FOR ACCESS TO MEDICAL INFORMATION

The Drexel Psychological Services Center (Drexel PSC) Notice of Privacy Practices provides information about our use of a client's protected health information. The Notice contains a Client Rights section describing your rights under the law. Clients have the right to access, inspect, and copy protected health care information used to make decisions about them.

Drexel PSC will only include information used to make decisions about the client. Drexel PSC may limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, Drexel PSC may withhold the requested information. The treating clinician will evaluate this Request and notify the client of our decision within fifteen (15) days of this Request. If the Request is approved, Drexel PSC will provide the information within thirty (30) days, or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the client upon approval of the Request. Drexel PSC may provide a summary of the requested information if you are agreeable.

Drexel PSC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Pennsylvania state law.

Patient Name: \_\_\_\_\_

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire: \_\_\_\_\_

\_\_\_\_\_

Is a summary of the information acceptable? \_\_\_\_\_

Do you wish to:

- Arrange an appointment to inspect the requested information?
- Receive a copy of the information?
- Have the information sent to a third party.

Instructions regarding copies.

- I will pick the copies
- Please mail the copies to me or to \_\_\_\_\_ at the following address:

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

This Request was made by: \_\_\_\_\_  
Printed Name - Patient or Representative

Signature of client or representative: \_\_\_\_\_

Relationship to Client (if other than client): \_\_\_\_\_

Date: \_\_/\_\_/\_\_

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Supervising clinician signature: Approval \_\_\_\_\_  
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