Community Mental Health Affiliates, Inc.

Access PHI (Record Request Form)

This form should be completed by the client or client's legal representative who is requesting a copy of the medical record for themselves. An ID is required of the person requesting the record and should be included with this form. Please ensure all highlighted areas are completed before submitting the form to Medical Records. Please contact Medical Records with any questions.

Medical Records Contact Info

Direct Line: 860-348-2310

Fax Line: 860-827-3473

Email: mrecords@cmhacc.org

Medical Record
233 Main St | New Britain, CT 06051 | P 860.348.2310 | F 860.827.3473

Request to Obtain or Access Protected Health Information

CLIENT NAME:	**DATE OF BIRTH:**
ADDRESS:	**MRN**:
	PHONE NUMBER:
REQUESTOR: ☐ Client ☐ Legal Representative	**EMAIL:**

This is a request for records that are maintained by Community Mental Health Affiliates, Inc. (CMHA.) Documentation is required for any client that has a legal representative, you may be asked to provide a copy of this documentation if we do not have it on file.

I would like to: (Select an option)

☐ Obtain **the entire** medical record.

-OR-

☐ Obtain a **portion** of the medical record as follows: (please include specific limitations on dates, episodes of care, other limitations and information to assist CMHA in providing access to a portion of your information):

-OR-

☐ I would like to **review** a copy of my medical record. I understand I will be contacted with a date and time for me to come in and review my record.

Once my record is processed, CMHA will call me at the phone number listed above to set up a day and time to pick up my record. If a copy of my ID was not included with my request, I understand a copy of will be required prior to me receiving my request.

I understand that my rights with regard to this request for access are set forth in CMHA's Notice of Privacy Practices.

_____ _____

Client or Legal Representative Signature Date