HUDSON VALLEY MENTAL HEALTH

REQUEST FOR INSPECTION AND/OR COPY OF PROTECTED HEALTH INFORMATION
HUDSON VALLEY MENTAL HEALTH, INC.

Client Name:_____ Clinician/Provider Name:_____

Phone Number (Day):_____Phone Number (Evening):_____

Street:_____City:_____State:_____Zip:_____

I, _____hereby request to inspect the following health
(Client Name)

information pertaining to me maintained at Hudson Valley Mental Health, Inc.: _____
_____
_____
_____

TO OUR CLIENTS: You have a right to request the opportunity to inspect and receive a copy of health information that pertains to you. Hudson Valley Mental Health, Inc. will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that the decision be reviewed by someone other than the person who originally denied the request.

_____ _____
Signature of Client **Date**

INTERNAL USE ONLY
Provider receiving request must determine to grant or deny request. If approval is granted for inspection, provider must contact the individual to arrange. If approval is granted for copying, the provider must send the requested information. If a denial is determined, the provider must include with this form and the reason for denial to the Dir. of QA/RM.

The request is hereby:

_____Granted
_____Denied

PLEASE NOTE: If the information is available at the time of the request, the provider can choose to release the information at the time of the request.

_____The request for the above information was provided to the client.

This Request for Inspection and/or Copy of Protected Health Information is to be scanned intothe client's medical record.