

# FAMILY CARE CENTER

## Client Records Management Request

Request For: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Please Print Name

Records Review: You were initially given a "Notice of Privacy Practices" and these indicated you have the right to review your clinical record for as long as the FCC maintains the MHI. Your chart/the clinical record will usually include both treatment and billing records. To inspect your MHI, you must send a written request to our clinical director (at FCC address). Forms for this are available at any FCC site. It is necessary to use this form to process your request. If the clinical director views your records as requiring supervision to safely interpret the contents, you will be billed at the same rate you receive treatment. Supervision will be scheduled as rapidly as possible according to staff availability. We will charge you a fee for the cost of copying, mailing, or other supplies that are necessary to grant your request (for example: when sending your records to another caregiver or for court-related services). We may deny your request to inspect the copy in certain limited circumstances. If you are denied access to MHI about you, you may request that the denial be reviewed.

Amendments to Records:

If you feel that the MHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the MHI. To request an amendment, you must send a written request to the clinical director (address listed above). Forms for this are available at any FCC site. You must use this form to ensure we receive adequate information to process your request. In addition, you must include a reason to support your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement or disagreement with the decision, and we may give you a rebuttal to your statement. This statement, and possible rebuttal, will be added to your MHI.

*Please check only the specific type of service you are requesting.*

- A.) \_\_\_\_\_ I am requesting that a copy of my mental health records to be sent to \_\_\_\_\_  
(I understand that legislation has been passed regarding the fees for mailing records and that the first ten (10) pages will be \$15, plus \$0.25 for every additional page. FCC will not charge for the postage related to mailing the material.)

Print Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

- B.) \_\_\_\_\_ I wish to have my chart records reviewed and understand this may require a supervised setting, similar to a treatment session which I would be obligated to pay for at the time of service.

- C.) \_\_\_\_\_ I wish to have my chart record amended. \_\_\_\_\_ Content added \_\_\_\_\_ Content removed  
*Please explain in detail the information you wish deleted or added and why.*

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Treating Therapist Signature (A, B, & C)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinical Director Signature (B & C) \*

\_\_\_\_\_  
Date

\* Note: The Clinical Director will need to sign for A if your therapist is unavailable or no longer with FCC

Client: \_\_\_\_\_

Chart #: \_\_\_\_\_