HENRICO AREA MENTAL HEALTH & RETARDATION SERVICES

CLIENT REQUEST TO ACCESS RECORDS

PLEASE READ CAREFULLY AND COMPLETE

Date: _____

Name of Client: _____
Last Name *Suffix (Jr., Sr. III)* *First Name* *MI*

Client Social Security Number: _____ Client's Date of Birth: _____

This request applies to the clinical record created by Henrico Area Mental Health and Retardation Services (HAMHRS) and other records used by HAMHRS to make decisions about the above named client. These records are called the "designated record set".

Request access to:

☐	View above named client's "designated record set"
☐	Obtain copies of the above named client's designated record set pertaining to: _____
☐	Obtain a copy of the above named client's entire designated record set

Copies of the records will be furnished for a fee. $0.50 per page up to 50 pages and $0.25 a page thereafter for copies from paper or other hard copy generated from electronic storage, $1.00 per page for any copies from microfilm, plus all postage and shipping costs and a $10.00 search and handling fee.

_____ _____
Signature of Client *Date*

_____ _____
Signature of Legally Authorized Representative *Date*

If different from Client:

Name of Person Requesting Access: _____
(please print)

Phone Number: _____

Address: _____

Relationship to Client is:

☐ Legal Guardian ☐ Authorized Representative ☐ Other: _____

_____ **Initials of HAMHRS staff who verified relationship documentation**

***Mandatory* Acknowledgement**

Complete below, return a copy as acknowledgement of request to Requestor within 5 business days and ensure REC470 Letter – Response to Request to Exercise Individual Rights completed within 15 days of request.

☐ Request acknowledged _____ _____
Name of Staff Acknowledging Request Phone Number