VIEW POINT Health
A Total Care Perspective

Client Name			Date of Birth *(mm-dd-yyyy)*
Mailing Address			Apt/Suite/Lot #
City	State	Zip Code	Phone Number

REQUEST TO REVIEW OR RECEIVE A COPY OF PROTECTED HEALTH INFORMATION (PHI)

By signing this document, I affirm that I understand the following procedure. I may contact the View Point Health Medical Records Department regarding any questions at (678) 209-2403 or MedRecs@VPHealth.org

1. My clinical team will review the records to determine if there are concerns that gaining access to these records would endanger the life or physical safety of myself or someone else and therefore, may deny my request.
2. View Point Health has 30 calendar days in which to complete this request.
   I will be required to pay a fee that will be invoiced to me for my records, after my request is reviewed.
3. I understand that if I am requesting to review my records, I will be contacted to schedule an appointment during View Point Health's regular business hours.

☐ **I would like a copy of the records.** ☐ **I wish to review the records identified below.**

PLEASE CHOOSE DELIVERY METHOD

☐ Mailed to me (address listed above)

☐ Electronic via email (list email address): _____
Note: PHI sent electronically will be password protected

☐ Pick-Up at a View Point Health Location (Please specify location): **Select a Pick-Up Location**

Service Dates Being Requested: FROM _____ TO _____

Types of Records (Check all that apply)

☐ Complete Record ☐ Diagnosis ☐ Medication List ☐ Progress Notes *(excludes psychotherapy notes)*
☐ Assessments ☐ Lab Results/UDS Results ☐ Discharge Summary
☐ Treatment Plan ☐ Appointment Dates/Times
☐ Other, please specify: _____

Medical Records Retrieval Rates

Copying per page fee for pages (1-20):	$0.75
Copying per page fee for pages (21-100):	$0.65
Copying per page fee for pages (over 100):	$0.50

*If the **complete record** is being requested, please be advised your invoice may approximately be more than $100.00*

Client Signature (required) ▶	**Date** (required) *(mm-dd-yyyy)*
Printed Name of Person Signing **(if not client)** *(First, Middle, Last)*	

Relationship to Client: ☐ Biological/Adoptive Parent ☐ Legal Guardian ☐ Legal Authorized Representative

If signed by client's Legal Guardian/Authorized Representative, supporting legal documentation must accompany this form if not already on file. Failure to submit proof of legal authority will result in request being invalid.

▶ Submit a photocopy of the front and back of photo ID with this form.

PRINT