

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

**CLIENT REQUEST TO ACCESS RECORDS**

PLEASE READ CAREFULLY AND COMPLETE

Date: \_\_\_\_\_ Client Name: \_\_\_\_\_

Client Social Security Number: \_\_\_\_\_ Client's Date of Birth: \_\_\_\_\_

This request applies to the clinical record created by Henrico Area Mental Health and Developmental Services (HAMHDS) and other records used by HAMHDS 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: (Print) _____
Phone #: _____
Address: _____

Relationship to Client is:

- Legal Guardian
- Authorized Representative
- Other: \_\_\_\_\_

\_\_\_\_\_  
**Initials of HAMHDS staff who verified relationship documentation**

<b>Mandatory Acknowledgement</b> <i>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.</i>
<input type="checkbox"/> Request acknowledged _____
Name of Staff Acknowledging Request <span style="float: right;">Phone Number</span>