RESET FIELDS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

REQUEST TO ACCESS, INSPECT OR OBTAIN A COPY OF PROTECTED HEALTH INFORMATION

Individual's Name: _____ Birth Date:_____

Recipient Number: _____

Individual's Address: _____

I am requesting (check where applicable) ☐ access to and/or ☐ a copy of my record. I know that I do not have a right to access psychotherapy notes or information compiled in anticipation of a legal proceeding.

The fee for this request will be: _____(to be completed by the program office)

I understand that action will be taken on this request within 30 days of the Department's receipt of the request. If the information is not readily accessible to the Department, action will be taken no later than 60 days after the request. I understand that the Department may extend the above time limits by 30 days.

_____ _____
Signature of Individual or Personal Representative Date

FOR PROGRAM OFFICE USE ONLY:

Date Received: _____ ☐ Approved ☐ Denied

Extension:

Staff member processing request:_____

Comments:

Date copy provided: _____