COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

# *Request to Inspect or Receive a Copy of Protected Health Information*

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

*DMH facility/office/program to which I am submitting this request:* ____________________________________
__________________________________________________________________________________________

*I understand that I have the right to inspect or receive a copy of my Protected Health Information (PHI) maintained by DMH in a Designated Record Set. I understand that there may be a fee for copies and that I will be informed of any fee in advance. I understand that my request to access my PHI may be subject to some limitations. I also understand that DMH will respond to this request in 30 days or less unless I receive notification in writing that it will take longer to process my request.*

*Specific types of PHI or records that I wish to review:* ____________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
.
*Date(s) of Service:* ______________________________________________________________________
__________________________________________________________________________________________

*If applicable, name(s) of other DMH facilities/offices/programs where the PHI or records I wish to review may be located:* ______________________________________________________________________
__________________________________________________________________________________________

_____ *I wish to visually inspect the PHI or records identified above during regular business hours at the DMH facility/office/program listed above.*

_____ *I would like to receive a copy of the PHI or records identified above.*

- _____ *Copy to be mailed to the address given above.*
- _____ *Copy to be mailed to this address:* _____________________________________________
- _____ *Copy to be picked up at time and place designated by DMH.*

_____________________________________________ ________________________________

*Your signature or Personal Representative's signature* *Date*

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

_____________________________________________
Print name

Type of authority (e.g., court appointed, custodial parent): ________________________________

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**Request To Inspect or Receive A Copy of Protected Health Information (continued)**

For DMH Use

Name: ______________________ Requester (If Different): ______________________

Date request received: ______________ DMH location where request received: ______________

Received by: ______________________ ______________________
(signature) (print name)

REVIEW OF REQUEST

Reviewer: ______________________ Date: ______________
(print name)

☐ Referred on______________ (date) to ______________________(name) a Licensed Health Care Professional for the following reasons:______________________

☐ Coordination required with the following Record Coordinators: ______________________
Comments______________________

Review Decision
___ Approved ___ Denied
___ Approved in part and denied in part. Specify the part denied______________________

Denial Reason(s):______________________

Action taken: ☐ Denial Letter sent on ________ ☐ PHI sent on ________ ☐ Access Provided on ________

Reviewer's Signature:______________________

REVIEW BY LICENSED HEALTH CARE PROFESSIONAL
(if applicable)

Licensed Healthcare Professional: ______________________ Date: ______________
( print name)

Safety Determination
___ No Safety issues. The request can be approved in full.
___ Safety Issues. The request must be denied as follows (specify if the request is to be denied in full or in part and, if in part, what part(s): ______________________

Reason/Comment: ______________________

______________________ ______________________
Licensed Health Care Professional Signature Title