WellPower

Information about Requesting Health Records

Access Request

What is a request to access health records?

When an individual is requesting access to view or receive copies of their own documented health information.

What are the options for access?

Viewing – A time and date can be arranged to view the health records in person at our Dickenson location or through a virtual meeting.

Copies – Can be provided of either the entire health record, or certain parts, in the format and to the location of choice.

Form & Format Options:

- Electronic* sent via secure email or e-fax
- Electronic* on CD sent via certified post or picked up
- Electronic* on USB sent via certified post or picked up
- Printed sent via post or picked up

*Electronic copies are in PDF format and will require PDF reader software to view.

Online Portal – For more information, please go to:
www.wellpower.org/telehealth/#app

Do I have to pay anything for an access request?

Maybe. If fees are applied, an invoice will be provided with the total and instructions on how to make payment. Payment may been to be made before health records will be released.

WellPower is a non-profit organization focused on the well-being and service of the Greater Denver area. The fees applied to your request help continue to support those services to the community.

FORM & FORMAT	FEE
Viewing	No fee
Copies	
Secure e-mail*	
Compact Disc*	$6.50 flat fee
Jump Drive*	
Printed Paper	Fee is calculated based on cost of materials and postage, never to exceed $25. Paper copies can also be notary certified, if needed, at $10 per section.

*Electronic copies are in PDF format and require PDF reader software to view.

DOCUMENT TYPE	FEE
Administrative Paperwork	No fee
Summary of Services	No fee
Medication List / Labs / Diagnosis	No fee
(Neuro)psychological Report	No fee for first copy

**other exceptions may apply

Third-Party Request

What is a third-party request for health records?

When an individual is requesting health information to be released to a person and/or organization outside of WellPower, such as attorney/public defender, outside healthcare provider, social security, insurance, probation/parole, etc.

What are the options for third-party?

Copies - Can be provided of either the entire health record, or certain parts, in the format and to the location of choice.

Form & Format Options:

- Electronic* sent via secure email or e-fax
- Electronic* on CD sent via certified post or picked up
- Electronic* on USB sent via certified post or picked up
- Printed sent via postal mail or picked up

*Electronic copies are in PDF format and will require PDF reader software to view.

Do I have to pay anything for a third-party request?

If the request is to send records to a third-party, fees are applied per Colorado state regulations and are to be paid for by the third-party. If fees are applied, an invoice will be provided with the total and instructions on how to make payment. Payment must be received before health records will be released.

WellPower is a non-profit organization focused on the well-being and service of the Greater Denver area. The fees applied to your request help continue to support those services to the community.

Fees are waived for requests:

- To other healthcare providers
- To probation or parole departments / courts
- To department of human services
- To grant awardees of the Laura Hershey Disability Act ("LHA")
- By court order

**Additional exceptions may apply.

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Can the request be denied?

Yes. Some requests for access are reviewed by designated mental health professionals who determine whether the request will be granted in-whole, granted in-part, or denied. State and federal statutes outline specific conditions for granting or denying access to health information.

If the request has been denied in part or in full, the requestor will be notified. If the denial is eligible for an appeal, the requestor can initiate a request for review by contacting the HISM team. Information on how to submit an appeal will be included with the denial notification.

What information is released/shared?

Only what is permitted and/or authorized for release and is the minimum needed to fulfill the purpose of the request.

Who can sign off on a request for health information?

The individual who is the subject of the health information or their "*personal representative*," if applicable.

A "*personal representative*" is anyone who has legal authority to make decisions about the individual's healthcare, including rights to access the health record. This could be a parent or parents (for unemancipated minors) who maintain(s) medical decision-making authority, a court-appointed legal guardian, someone with healthcare power of attorney, etc.

As applicable, supporting documentation must be included with the request, such as birth certificate, court order, or healthcare power of attorney.

How long does it take?

All requests will be reviewed by the Health Information Systems Management ("HISM") team and an initial response will be issued within ten business (10) days. Requests can take up to fifteen (15) to thirty (30) calendar days to complete.

How much time is needed depends on the nature of the request, the number of requests already in queue, any need for additional documentation, and occasionally due to staffing. HISM will notify the requestor if anything else, and/or more time, is needed.

If a request is time sensitive, it is important to give ample time for a request to be completed.

How do I submit the request?

Access Request

A written request must be submitted to the HISM team. There are two options on how to do this:

1. Complete and hand sign the attached "Request for Access to Health Information" form. It can also be downloaded online at www.wellpower.org/health-records. Submit the completed form to the HISM team by email, fax, postal mail, or in-person (contact information provided below). A readable copy of the requestor's valid government-issued ID must be included to verify signature.

OR

2. Complete and e-sign the "Request for Access to Health Information" form online using docusign. You can do this by going to www.wellpower.org/health-records or by contacting the HISM team to complete over the phone.

Once we receive the completed form, we may reach out to you to confirm your request, with any questions, and/or to coordinate any next steps.

Third-Party

A written request must be submitted to the HISM team. There are three options on how to do this:

1. The third-party directly submits a written request for the information to HISM (this is the most common option).

OR

2. Complete and hand sign the attached "Authorization to Release Protected Health Information" form. It can also be downloaded online at www.wellpower.org/health-records. Submit the completed form to the HISM team by email, fax, postal mail, or in-person (contact information provided below). A readable copy of the requestor's valid government-issued ID must be included to verify signature.

OR

3. Complete and e-sign the "Authorization to Release Protected Health Information" form online using docusign. You can do this by contacting the HISM team to complete over the phone.

Contact Information

Health Information Systems Management
4141 East Dickenson Place (Office 170), Denver, Colorado 80222
303.504.6510 main | 303.504.6504 fax
HISM@wellpower.org
www.wellpower.org/health-records

WellPower 303.504.6500 main | wellpower.org

Request to Access Health Records

Person Served Information

Please complete the following information about the person whose health records are being requested.

First Name: _____ M.I.: _____ Last Name: _____

WellPower ID#: _____ Date of Birth: _____ *(mm/dd/yyyy)*

Request Type

Please select the type of access you are requesting. Fees may apply.

- ☐ Electronic copy: secure e-mail (*PDF only)
- ☐ Electronic copy: CD (*PDF only)
- ☐ Electronic copy: Jump Drive (*PDF only)
- ☐ Printed paper copy
- ☐ Printed paper copy: notary certified
- ☐ Viewing: *A representative from HISM will contact you to schedule.*

Receipt

Please select how you would like to receive your copies. Leave blank if not applicable.

- ☐ Postal Mail
- ☐ Pick-up
- ☐ E-mail (*for PDF only)

Treatment Information

(OPTIONAL) *Please select the time-period and/or program(s) of the health records you are requesting access.*

Service Dates: From: _____ To: _____ Program(s): _____

Information Requested

Please select to which parts of the health record you are requesting access.

- ☐ Entire Clinical Chart

OR

- ☐ Medication List
- ☐ Lab Results ☐ Pharmacogenomic Test
- ☐ Diagnosis Information
- ☐ Other: _____
- ☐ Discharge Summaries
- ☐ Intake Assessment(s)
- ☐ (Neuro)Psychological Evaluation
- ☐ Residential Shift Notes
- ☐ Case Management Summaries
- ☐ Psychiatry/Medical Summaries
- ☐ Crisis Intervention Summaries
- ☐ Psychotherapy Progress Summaries

Requestor Information

If you are requesting access to health records on behalf of the person in services, please fill in your information below.
NOTE: *Supporting documentation of your legal authority to access these health records must be provided, if not already on file. Leave blank if not applicable.*

First Name: _____ M.I.: _____ Last Name: _____

Organization: _____ Relationship: _____

Requestor Contact Information

Street Address: _____ City, State _____ Zip: _____

Email: _____ Phone: _____

_____ _____

Requestor Signature Signature Date

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Authorization to Release Confidential and Protected Health Information

Legal Name (please print) _____ Date of Birth _____ WellPower ID# _____

In accordance with federal rules, 42 CFR part 2 (Confidentiality of Substance Use Disorder Patient Records) and 45 CFR part 164 (Health Insurance Portability and Accountability Act of 1996), **I authorize the release of information about me as indicated below.** I understand information about any of the following may be included in the release: behavioral health, sexuality and reproductive health, HIV/AIDS, sickle cell anemia, communicable diseases, drug and alcohol use, and treatment for a substance use disorder.

WellPower

4141 E. Dickenson Place
Denver, CO 80222

_____ P

_____ F

Third-Party

Name: _____
(organization &/or individual)

Relationship: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Additional: _____

Verbal Communication: Do you authorize two-way verbal (oral) communication between WellPower and Third-party? ☐ Yes ☐ No

Written or Electronic Records: WellPower is authorized to release records? ☐ Yes ☐ No
Third-party is authorized to release records? ☐ Yes ☐ No

Type of Information Authorized to be Released:

☐ All information maintained in my record, **OR**
☐ Only the types of information/records checked below (check all that apply):

☐ Billing records	☐ Diagnosis list	☐ Employment info	☐ Physician summaries
☐ Clinical assessment(s)	☐ Discharge summary	☐ Laboratory results	☐ Progress summaries
☐ Continuity of care document (CCD)	☐ Education plan (IEP)	☐ Medication history/orders	☐ Psychological testing
☐ Demographics	☐ Education records	☐ Parole/Probation info	☐ Psychiatric evaluations
☐ Other (must specify): _____			☐ Service/Treatment plans

Time Period: (check only one)

☐ All admissions ☐ Most recent admission ☐ Dates _____ to _____

Purpose:

☐ Continuity of care ☐ Coordination of services ☐ Treatment ☐ At the request of the individual
☐ Other (must specify): _____

Re-disclosure

I understand that information disclosed based on this Authorization, except for information about a substance use disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosure and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2).

Prohibition on Conditioning of Authorizations

I understand that I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. WellPower may not refuse to treat me if I refuse to sign this Authorization, unless this Authorization is necessary for my participation in a research study, or the purpose of the treatment is to provide information to the individual/entity identified in this Authorization.

Expiration and Right to Revoke (Cancel)

I understand that I may revoke this Authorization at any time, except to the extent that information has already been disclosed or obtained in reliance on it. The revocation must be in writing. If not revoked, this Authorization will expire two (2) years from the date I sign it unless an earlier date is specified here: _____.

Authorization

My signature below means I understand and accept the terms of this Authorization. A copy of this Authorization (including a fax) is as valid as the original. I have a right to receive a copy of the signed Authorization.

X _____ _____

Signature of individual or personal representative — Signature date

_____ _____

Name of personal representative (if applicable) — Relationship

NOTICE TO RECIPIENTS

This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.