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: _____

Contact Information

Street Address: _____ City, State _____ Zip: _____

Email: _____ Phone: _____

_____ _____

Requestor Signature Signature Date