Health Information Management
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HISM@wellpower.org
www.wellpower.org/health-records

Request for Access to my Health Records

This form is used to make a request for copies or viewing of your own health records if you are the person in services, or by the personal representative (as defined in HIPAA) of the person in services. For requests to release information to someone other than yourself or other than to a personal representative, please go to our website and review the information for a Third-Party request.

Section 1: Person in Services

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

Preferred Name: _____ Pronouns: _____

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

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

Section 2: Personal Representative Information (*if not the person in services*)

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.*

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

Organization: _____ Relationship: _____

Section 3: Requestor Contact Information

Mailing Address: _____ City, State _____ Zip: _____

Email: _____ Phone: _____

Section 4: Disclosure Options

Please select how you would like to receive the records you are requesting.

Electronic Copies (PDF only)

- ☐ Electronic copy: secure e-mail
- ☐ Electronic copy: CD – by postal mail
- ☐ Electronic copy: CD – picked up
- ☐ Electronic copy: USB Drive – by postal mail
- ☐ Electronic copy: USB Drive – picked up

Printed Copies

- ☐ Printed paper copy – by postal mail
- ☐ Printed paper copy – picked up

Additional Service

- ☐ Notary certified copies (additional fee)

Viewing

- ☐ Viewing:
  A representative from HISM will contact you to coordinate & schedule.

Section 5: Purpose (optional)

☐ Personal Use ☐ Continuity of care ☐ Disability Benefits ☐ Worker's Comp ☐ Employment screen
☐ Civil/Criminal Proceeding ☐ Other: _____

Section 6: Information Requested

Please select what information from the health record you are requesting.

☐ **Entire Health Record** (includes everything listed below, as applicable) **OR select the specific information you want below:**

- ☐ Medication Information
- ☐ Diagnosis Information
- ☐ Lab Testing Results
- ☐ Pharmacogenomic Testing Lab Results
- ☐ Admission Mental Health Assessment(s)
- ☐ (Neuro)Psychological Assessment Report(s)
- ☐ Other: _____

Service summary notes for:

- ☐ Psychotherapy
- ☐ Crisis services
- ☐ Psychiatry
- ☐ Primary Care
- ☐ Residential
- ☐ Case management
- ☐ Rehabilitative services (resource center, supported employment, supported education)

Service Dates: (optional) From: _____ To: _____

Program(s): (optional) _____

Section 7: Signature

PLEASE INCLUDE A COPY OF YOUR VALID, GOVERNMENT-ISSUED PHOTO ID. Fees may apply.

_____ _____
Requestor Signature Signature Date