

How do I request copies of health records?

If you are the person in services requesting copies of your own health records, or a personal representative (as defined in HIPAA) requesting copies of health records, for yourself – please read information about “Access Requests” below:

Access Requests

Create an online portal account or download the WellPower app. For more information, please go to:

www.wellpower.org/wellpower-app

AND/OR

Submit a written request by:

1. Download & submit a hard copy: Complete and hand sign the “Request for Access to Health Information” form. It can be downloaded online at www.wellpower.org/health-records. The form must be signed by the person in services, or personal representative (if applicable). 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 photo ID must be included.

OR

2. Complete & submit an electronic copy: 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. The form must be signed by the person in services, or personal representative (if applicable). A readable copy of the requestor’s valid government-issued photo ID must be included.

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.

If you are the person in services, or personal representative (as defined in HIPAA) requesting copies of health records to be sent to someone else, or someone else requesting copies for yourself – please read information about “Third-Party Requests” below:

Third-Party Requests

Submit a written request by:

1. (This is the most common option) The third-party directly submits a written request for the information to HISM with a valid signed “Authorization to Release Confidential & Protected Health Information.”

OR

2. Download & submit a hard copy: Complete and hand sign the “Authorization to Release Confidential and Protected Health Information” form. It can also be downloaded online at www.wellpower.org/health-records. The form must be signed by the person in services, or personal representative (if applicable). 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 photo ID must be included.

OR

3. Complete & submit an electronic copy: Complete and e-sign the “Authorization to Release Confidential and Protected Health Information” form online using docusign. The form must be signed by the person in services, or personal representative (if applicable). You can do this by going to www.wellpower.org/health-records or 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.

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 signed by the judge, or healthcare power of attorney.

How long does it take?

All requests will be reviewed by the Health Information Systems Management (“HISM”) team. Requests can take up to thirty (30) calendar days to complete. If a request is time sensitive, it is important to give ample time for a request to be completed. How much time is needed depends on the nature of the request, the number of requests already in queue, any need for additional documentation or information, and occasionally due to staffing.

In what form and format can I receive the health information?

- Electronic copy (PDF file)* sent via secure email or e-fax
- Electronic copy (PDF file)* on CD sent via certified postal mail or picked up
- Electronic copy (PDF file)* on USB drive sent via certified postal mail or picked up
- Printed hard copies sent via postal mail or picked up
- **Viewing** (for access requests only) - a time and date can be arranged to view the health records in person at our Dickenson location or through a virtual meeting.

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

Are there fees for the request?

If fees are applied, an invoice will be provided with the total and instructions on how to make payment. 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.

Access Request

Viewing: No fee

PDF copies by email: \$6.50 flat fee

PDF copies on CD or USB drive & picked up: \$6.50 flat fee

PDF copies on CD or USB drive & by postal mail: \$6.50 + postage

Printed hard copies: Fee is calculated based on cost of materials, never to exceed \$25. Additional fees for postage costs and/or notary certified copies.

No fees for:

- Administrative paperwork
- Summary of services reports
- Medication list
- Lab testing results
- Diagnosis information
- (Neuro)psychological assessment report

**other exceptions may apply

Third-Party Request

Fees are applied per Colorado state regulations and are to be paid for by the third-party. Additional fees for postage costs and/or notary certified copies.

No fees for requests:

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

**other exceptions may apply

Can the request be declined?

Yes, see below:

Access Request

The request is reviewed by designated licensed health professionals who determine whether the health information requested will be released in-whole, in-part, or entirely declined. 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 a denial review. Information on how to submit an appeal will be included with the denial notification.

Third-Party Request

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

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



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)	Printed Copies	Viewing
<input type="checkbox"/> Electronic copy: secure e-mail	<input type="checkbox"/> Printed paper copy – by postal mail	<input type="checkbox"/> Viewing: A representative from HISM will contact you to coordinate & schedule.
<input type="checkbox"/> Electronic copy: CD – by postal mail	<input type="checkbox"/> Printed paper copy – picked up	
<input type="checkbox"/> Electronic copy: CD – picked up		
<input type="checkbox"/> Electronic copy: USB Drive – by postal mail	Additional Service	
<input type="checkbox"/> Electronic copy: USB Drive – picked up	<input type="checkbox"/> Notary certified copies (additional fee)	

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:**

<input type="checkbox"/> Medication Information	Service summary notes for:	<input type="checkbox"/> Residential
<input type="checkbox"/> Diagnosis Information	<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> Case management
<input type="checkbox"/> Lab Testing Results	<input type="checkbox"/> Crisis services	<input type="checkbox"/> Rehabilitative services (resource center, supported employment, supported education)
<input type="checkbox"/> Pharmacogenomic Testing Lab Results	<input type="checkbox"/> Psychiatry	
<input type="checkbox"/> Mental Health Assessment(s)	<input type="checkbox"/> Primary Care	
<input type="checkbox"/> (Neuro)Psychological Assessment Report(s)		
<input type="checkbox"/> Other: _____		

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

Section 7: Signature

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

Requestor Signature _____ Signature Date _____