Amy Meek Family Therapy Group
Child, Adolescent, & Adult Therapy
316.788.6464ph/ 206.299.1262 fax

Request for Access to Protected Health Information

Use this form to request access to your Protected Health Information. Complete this form in its entirety to ensure your Protected Health Information can be located and released. Once the request is approved, a copy of your Protected Health Information will be available for you or your authorized personal representative.

Section 1: Protected Health Information Requested For:

Name_____Address_____City_____ State_____ Zip _____

Phone_____ Date of Birth_____ Male____ Female_____

Relationship to Patient: Self_____ Spouse ____ Child_____ If other, describe_____

Section 2: Type(s) of Information Requested

Please choose one of the three options below to indicate what type(s) of information you would like to receive:

☐ (Option 1) I would like a report that summarizes my treatment and diagnosis information.

☐ (Option 2) I would like the following information (if applicable):

- ☐Forms completed at Intake
- ☐Diagnosis
- ☐Testing Completed
- ☐Letter/ Correspondence explain to whom or dates:_____
- ☐Summary of Billing/ Claims
- ☐Phone Call/ Consultation explain to whom or dates:_____

☐ (Option 3) I would like a copy of the file from the EHR and a summary of treatment.

Section 3: Date Range of Information Requested

I would like this information for the following dates:

☐From _____ (MM/DD/YY) to _____(MM/DD/YY)

Section 4: Fees for Copies of Records

In compliance with Kansas Open Records Act, AMFT Group charges fees to provide copies of records and will apply guidelines and fee schedules established. There is a $35 fee for basic file copying , due to staff time involved in copying both paper and EHR records, and .25 per page. Summaries and reports are billed at an hourly rate per the Agreement for Services, and there is a minimum of a $60 fee for those services. Fees are due prior to receiving records or reports.

An authorized signature of the individual, or authorized signature of the personal representative of the individual, who is requesting the Protected Health Information is required:

I authorize the release of my Protected Health Information to me. I understand that this request does not apply to certain health information, including: (1) information that is not received or maintained by Amy Meek Family Therapy

Group; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not available for access under HIPAA.

Signature of Patient/ Legal Guardian Date

Printed Name and Relationship

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to supply a copy of legal documentation.

Please return the completed form to:

Amy Meek Family Therapy Group
1415 N. Buckner
Derby, KS 67037
316.788.6464 Phone
206.299.1262 Fax

Office Use Only

Received Date_____ Staff_____

Reviewed with Clinician Date_____

Total for Records/ Report_____ Patient Pd_____

Patient Contacted for Records to be Picked up Date_____Staff_____

Records Provided to Patient _____

Method_____