

**REQUEST FOR ACCESS**

*CLIENT (OR LEGAL REPRESENTATIVE): Please complete and date and sign where indicated*.

**Date of Request**:

**Client Name:** **Date of Birth:**

(Please print)

**Client Address:**

**Address to send requested health information**

(if different than above):

**Access**  
I would like access to the following health information:

I would like access to my health information in the following format (*Please Check one):*

Copy

Summary/ Explanation

Other

(*Please note: If the information cannot be provided in the form you request, we will provide a readable hard copy of your health information.)*

**Fees:**

*I understand that I will be charged for any copies or postage I receive, or for the costs of preparing a summary or explanation of my health information*. I also understand that the Agency will notify me of its decision to allow or disallow me access to my health information in writing in 30 days. *[Instructions: Costs must be filled in before giving form to Client.]*

Cost per Copied page: $1 per page for the first ten, $.50/page for pages eleven through fifty; $.20 for 50+ pages

Cost of Postage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­

Cost for preparing summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cost for preparing explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  
Signature of Client or Legal Representative Date

Email to [mcox@gladhouse.org](mailto:mcox@gladhouse.org)

Mail to 1994 Madison Road, Cincinnati, OH 45208 Fax to 513-482-7042