VIRGINIA COMMONWEALTH UNIVERSITY

Center for Psychological Services and Development

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REQUEST TO VIEW OR OBTAIN A COPY OF RECORDS

RIGHTS/RESTRICTIONS ON ACCESS TO PERSONAL MEDICAL RECORDS

Under federal law, we may only provide a "Designated Record Set (DRS)" of your personal medical records. This DRS contains your medical and billing records we physically store and maintain on our premises and only includes those portions of medical records that are used to make decisions about your mental health care.

We are not able to provide:

- Items not maintained in legal health records
- Education records exempt from HIPAA
- Psychotherapy Process Notes
- Raw test data summarized in the medical record

If your records are in paper format, you may request a photocopy of your DRS.

If your records are maintained in our Electronic Medical Records (EMR) system, you have the right to obtain an electronic copy of your DRS via email. If you prefer, we can provide a paper copy of your electronically stored records.

You have the right to inspect your records without obtaining a copy. We require that you make an appointment with your therapist or a CPSD staff member to view your DRS between 9am and 5pm on Monday through Thursday.

We make every attempt to respond to and fulfill your request within 5 business days.

WAIVER OF PROTECTION FOR ELECTRONIC DELIVERY OF MEDICAL RECORDS

Both electronic mail and fax transmissions are unsecured mediums. If you request that your records be delivered via email, you may instruct us to add a password to the file containing your records and / or to encrypt the email itself. Alternatively, you have the right to waive all protections of your medical records that are delivered via email. Records delivered via fax cannot be encrypted or password protected. CPSD cannot guarantee the privacy of any message that is delivered electronically.

FEES

The fee to review your DRS is $5.00. The minimum processing fee for one copy of your DRS is $5.00.

If you request photocopies and your DRS exceeds 50 pages, you will be charged the minimum fee plus 10¢ per page for each page over 50.

You may also instruct us to send one copy of your records by fax to any medical or mental health provider named below at no charge.

Provider Name: _____

Provider Address: _____
Street City/State Zip

Provider Email: _____ Phone _____ Fax _____

DENIAL OF ACCESS TO PERSONAL MEDICAL RECORDS

We may legally deny your request for access to your medical records, without the opportunity for appeal, in the following circumstances:

- Your records were created in the course on ongoing research and disclosure would jeopardize the research. You must have agreed, in writing, to such a restriction previously and, if so, your right of access will be restored at the conclusion of the research.

We may legally deny your request for access to your medical records, with the opportunity for appeal, if access is reasonably likely:

- to endanger your life or the life of another person or
- to cause substantial harm to you or to another person.

REQUEST

Client Name: _____ DOB _____

Name of person requesting records (if other than client): _____

Relationship to Client: _____

Telephone Number: _____

Delivery instructions for <u>one</u> copy of records **(select one – CPSD will honor the topmost selection)**:

☐ Mail photocopies to:

Address: _____
Street City, State Zip

☐ Hold photocopies – I will retrieve them at the CPSD's front desk (photocopies will be destroyed after 30 days)

☐ Email electronic files (please select all that apply):

☐ Add a password to the file containing my records. I understand that the CPSD will contact me at the telephone number above with the password.

☐ Add encryption to email. I understand that I will log into a secure email service to retrieve my records.

☐ Do not take precautions for the electronic file or email. I understand that the file may contain my Protected Health Information and will be transmitted through an unsecure medium.

Email address (please print): _____

☐ Fax photocopies to: Telephone number: _____

SIGNATURE

This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms in this form.

_____ _____
Client or Person Requesting Records Signature Date

Office use only: DRS Filetype ____ electronic ____ paper ____ hybrid