



CLIENT ACCESS TO PROTECTED HEALTH INFORMATION (PHI FORM)

(Form must be filled out completely in order to be valid)

Diversus Health may deny access to all or part of my record if they believe there is a potential risk to me or someone else, or for legal reasons. Some, but not all, denials may be appealed. Diversus Health will inform me in writing about their decision and any appeal process I am entitled to. Diversus Health has 30 days to respond to this request. If extra time is needed, the agency will inform me in writing.

DATE: _____ PHONE: _____ CLIENT ID: _____

CLIENT NAME (please print): _____ DOB: _____

MAILING ADDRESS: _____

If client is 12-17 years old, please check box

1. Choose One: I am the client
 I am the parent of the client, and the client is **under 18 years old** and not emancipated
 I am a legally authorized representative of the client.
(Legal representative MUST provide documentation of their right to represent the client)

2. I am requesting: Diversus Health Clinical Record Diversus Health Clinical and Billing Record

3. Choose Method: Choose One

****Please note:** If you choose paper, records over 200 pages will be put on CD and mailed to address provided above**

- Paper** (pick up at one of our locations) **
 Child & Family: 179 S Parkside Dr, Colorado Springs, CO 80910
 Jet Wing: 1795 Jet Wing Dr, Colorado Springs, CO 80916
 Lighthouse: 115 S Parkside Dr, Colorado Springs, CO 80910
 Moreno: 875 W Moreno Ave, Colorado Springs, CO 80905
- Email** (receive via encrypted mail - unlimited pages)
 Email address: _____
- CD:** Computer Disk (receive via Mail - unlimited pages - Mailed to address that was provided above)

4. Date Range* of Records being requested: _____ to _____

*If unsure of date(s) needed, call us at 719-314-4283. If "ALL" is written, the last 12 treatment months will be provided.

5. Information being requested: Treatment/Safety Plan Medication Diagnosis Letter
 Assessment/Evaluation Psychological Test/Reports Labs Crisis
 Psychiatric Evaluation Discharge Summary Inpatient (ATU) Progress Notes
 Other: _____

6. Please state the reason for your request (Legal Representatives MUST give a reason)

If for court, when is your court date? _____

Please note per our Legal Department, please provide court documents regarding your court case. Upload court paperwork at <https://fs3.formsite.com/DiversusHealth/ng4cvvzukur/index.html> OR give copy to the front desk.

X _____
Client or representative signature

X _____
Diversus Health Staff verifying request (PRINT)

X _____
If client is 12 years and over, client **MUST** sign

X _____
If representative, print name and give relationship

Please provide photo ID:

In Person: Give photo ID to front desk to make a copy

Online: click link to upload [Diversus Health PHI Form](#)