



CLIENT ACCESS TO PROTECTED HEALTH INFORMATION (PHI FORM)
(Form must be filled out completely 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 the address provided *

- ☐ Email (receive via encrypted mail - unlimited pages)
Email address: _____
☐ Paper (pick up at our Jet Wing location) **
1795 Jet Wing Dr, Colorado Springs, CO 80916
☐ Paper (receive via mail)
Paper Mailing Address (Please include City, State, and Zip) _____
☐ CD-Computer Disk (receive via Mail - unlimited pages)
CD Mailing Address (Please include City, State, and Zip) _____

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:
- | | | | |
|---|---|--|---|
| ☐ Assessment/Evaluation | ☐ Psychological Test/Reports | ☐ Medication | ☐ Diagnosis Letter |
| ☐ Psychiatric Evaluation | ☐ Discharge Summary | ☐ Labs | ☐ Crisis |
| ☐ Other: | | ☐ Inpatient (ATU) | ☐ Progress Notes |

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](#)