

LEE MENTAL HEALTH CENTER, INC.

HOW TO REQUEST COPIES OF CLINICAL RECORDS

1. COMPLETE AN AUTHORIZATION FORM.

An authorization form must be completed by the client or legal guardian. Each section on the form must be completed. Please tell us the exact type of information you need, and the name, address, and telephone number of the person who will receive the information. Mail, fax (239-275-4295), or take the completed authorization form to the Clinical Records Department (Building E) 2789 Ortiz Ave., Fort Myers, FL 33905.

2. PAY FOR THE COPIES.

There is a fee for copying records if you are requesting copies for yourself or an attorney. Clinical record copies cost \$1.00 per page for the first 25 pages, and \$0.25 per page after that. This is the cost of producing copies according to Florida law.

You will not be charged a fee if the copies are sent directly from Lee Mental Health Center to another health care provider. If the copies are sent to Social Security-Disability at their request, they pay for the copies, not you.

There is no charge if you want to review your clinical record. Please call the Clinical Records Department at (239) 275-3222, ext. 6503 to arrange this. An appointment must be made at least two days in advance.

3. RECEIVE THE COPIES.

Lee Mental Health Center's copy service, Confidential Copying, processes requests for information each week. The copy service will mail your copies, or you may arrange to pick them up. Please use the following numbers to contact the copy service:

Office phone #:	(239) 731-2329
Cell phone #:	(239) 560-1291
Fax #:	(239) 731-2989

If you would like to speak to someone in the Clinical Records Department about your request, please call (239) 275-3222 ext. 6503.

Lee Mental Health Center, Inc.
2789 Ortiz Avenue * Fort Myers, Florida 33905

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

CLIENT NAME _____ DATE OF BIRTH _____

AUTHORIZATION FOR (check as appropriate): REQUEST FOR INFORMATION RELEASE OF INFORMATION

I authorize Lee Mental Health Center to request/release information and/or records of the individual named above.

I understand that my clinical record may include information relating to HIV/AIDS, behavioral or mental health services, and/or substance abuse services. If this authorization covers information pertaining to a minor child, the undersigned represents that he/she is the legal guardian and primary custodian of the minor, with full authority to execute this authorization.

This information may be released to/requested from the following:

(1) Facility/Person _____
Address _____
The information and records are for the purpose
of _____
Information to be released includes (check one):
 all information
 specific information/reports, such
as _____

I understand that I have a right to cancel this authorization at any time by presenting my written cancellation to the Clinical Records Department. I understand that the cancellation will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not cancel this authorization, it automatically expires as follows:

PLEASE INITIAL ONE CHOICE:

Six months after the date on which my treatment is completed
 On ____/____/____
 One time only for current records/information

I understand that authorizing the disclosure of this information is voluntary. I do not need to sign this form in order to receive treatment. I understand that the above information may be disclosed by the recipient of the information. Most health care providers and insurance plans must follow federal rules protecting the privacy of health information. However, Lee Mental Health Center cannot guarantee that others receiving the information will protect it.

Client or Legal Representative Signature Date

If Signed by Legal Representative, Describe Relationship to Client Witness Signature

CLIENT NAME:

CASE #: