PLEASE PRINT LEGIBLY

CABINET FOR HEALTH AND FAMILY SERVICES
COMMONWEALTH OF KENTUCKY

DEPARTMENT FOR COMMUNITY BASED SERVICES
AN EQUAL OPPORTUNITY EMPLOYER M/F/D

DIVISION OF PROTECTION AND PERMANENCY

REQUEST FOR CLIENT'S ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

Client Name (Print)______________________________________
Client Address (Print)
(Street name & number) ______________________________________
____
_________________(City) ______________(State) ________(Zip)

Social Security Number___________________________________
Date of Birth __________Case Record #____________________
County where case record maintained________________________
Client's Telephone Number
(____)________________(Home) (____)_____________(Work)

Address to send information regarding request (if different than above)

Please specify the protected health information requested
____
____

Please specify the format for protected health information requested **Note: Not all formats may be available**
☐ Direct Access (specify DPP office)_______________ ☐ Paper ☐ Computer Disk ☐ CD ☐ Fax __________ ☐ Other____________
I agree to pay the associated cost-base fee with this request for access to PHI (**upon notification of fee only**) ☐ YES ☐ NO
Your cost $___________ Make check or money order payable to **Kentucky State Treasurer** (Do not send until notified of cost)
Your request will be processed within 30 days or you will be notified in writing of the delay (process of request not to exceed 60 days).

Please indicate the parent of a minor or any personal representative who is requesting access to client's PHI

Individual's Name	Relationship to Client

Signature of Client or__________________________________ Print name__________________________________ Date___________
Legal Representative__________________________________ Print name__________________________________ Date___________
Note: Personal Representative must include a copy of court authorization (e.g. custody, guardianship etc.)
Signature of Witness__________________________________ Print name__________________________________ Date___________
Witness Telephone Number (____)________________ Address____

Mail to Cabinet for Families and Children, Ombudsman's Office, 275 East Main St. (1E-B) Frankfort, Kentucky, 40621

Information Below for the CFC Ombudsman's Office Use Only

Date Received | Request for Access has been ☐ Approved ☐ Denied

Reason for denial without your right of review
☐ Psychotherapy Notes
☐ Patient agreed to denial of access
☐ PHI used for civil, criminal or administrative proceedings
☐ PHI obtained from source under promise of confidentiality
☐ Other____

Reason for denial with your right of review
☐ Reason to believe physical safety of client endangered
☐ PHI makes reference to third party and access may cause harm
☐ Personal representative is requesting party and client has been or may be subject to domestic violence, abuse or neglect

If the request is denied, you may file a complaint with the Cabinet for Families and Children, Compliance Office by calling (502) 564-5497 or with the Secretary of the Department of Health and Human Services, Region IV Office for Civil Rights by calling (404) 562-7886.

Date Sent to Records Management Section_________________ Name of staff processing request______________________________

Signature of Compliance Officer or designee Date

Information Below for the DPP Records Management Section

Date Received	Date written fee request sent to client	Date written denial sent to client	Date the disclosure sent to client
____________	______________________	____________________	_________________________

Extension Requested ☐ Yes ☐ No Client/Personal Representative notified in writing on this date_____________________
Reason for extension ____

Date entered in client's case record for PHI or sent to local DPP office to be entered

Name of staff processing request ______________________________________ Title ________________________