COMMUNITY CARE
Behavioral Health Organization

Request for Access to Protected Health Information

Instructions

You must complete this form, sign and date the form, and mail it to the address below in order for your request to be processed and considered.

Community Care Behavioral Health Organization
Privacy Officer
339 Sixth Avenue, Suite 1300
Pittsburgh, PA 15222

Community Care does not maintain medical records. You must contact your doctor or the hospital where you were treated for your medical records.

Please complete all the fields below.

Member Information

Member's Name: _____
(last, first, middle)

Member's Address: _____

Member's Medical Record Number: _____

Member's Date of Birth: _____ *(mm/dd/yyyy)*

Member's Phone Number: _____ *(no dashes)*

1. Please describe the information that Community Care has that you would like to access:

2. Please note the specific treatment time frames in which you would like access to your information:

3. Please note the address where you would like the information sent if the address is different from the one you wrote above:

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Member *(The person about whom the information relates, if 14 years of age or older)*	Date of Member's Signature	Member's Date of Birth or Medical Record Number

OR, if applicable -

Signature of Parent, Legal Guardian or Authorized Representative	Date of Parent, Legal Guardian, or Authorized Representative's Signature	Description of Authority to Act for the Member *(i.e., Parent, Legal Guardian or Authorized Representative)*

A copy of this completed, signed and dated form must be given to the Member or other signator.

Official Use Only

Received	Processed By	Log #