



La Junta, CO 81050  
Phone: 719-383-5458  
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## Southeast Health Group

### Protected Health Information Request by an Agency

Date: \_\_\_\_\_  In-Person       Telephone       Fax

Name of Agency: \_\_\_\_\_ Agency Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Person Requesting Information: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

This Protected Health Information Request is for the records summary of:

Name \_\_\_\_\_ DOB: \_\_\_\_\_

In order to request information about another individual, that person must sign a ***HIPAA Authorization for Release of Information form*** that specifically authorizes the Requestor to obtain their Protected Health Information.

Date ROI was signed: \_\_\_\_\_ Purpose for the request: \_\_\_\_\_

Information to be released:

Mental Health/ Psychiatric Condition     Alcohol Abuse/Substance Abuse     Other: \_\_\_\_\_

In response to your request, our policy is to provide the following:

1. A copy of the Intake Form, the 6 or 12 month Update Form or the Discharge Summary (whichever is most current).
2. An Outpatient Treatment Report.

If you are in need of specific session notes, those are considered by Southeast Health Group to be privileged communication between our agency and the patient.

Records requests may take up to ten business days to complete.

\_\_\_\_\_  
Signature of Person Requesting Information  
(Parent or Guardian if Minor Child)

\_\_\_\_\_  
Date

\_\_\_\_\_  
SHG Employee Signature

\_\_\_\_\_  
Date

Records were: Faxed  Mailed  Picked Up

by \_\_\_\_\_

\_\_\_\_\_  
Date