

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

INDIVIDUAL REQUEST TO ACCESS RECORDS

PLEASE READ CAREFULLY AND COMPLETE ALL SECTIONS

SECTION 1 — INDIVIDUAL INFORMATION

Date: _____ Individual's Name: _____

Individual's Date of Birth: _____

This request applies to the clinical record created by Henrico Area Mental Health and Developmental Services (HAMHDS) and other records used by HAMHDS to make decisions about the above-named individual. These records are called the **"designated record set."**

SECTION 2 — TYPE OF ACCESS REQUESTED

Select one option below:

- ☐ View the above-named individual's designated record set
- ☐ Obtain a copy of the above-named individual's entire designated record set
- ☐ Obtain copies of specific records pertaining to (check all that apply):
- | | |
|---|---|
| ☐ Psychological Evaluation | ☐ Psychiatric Evaluation |
| ☐ Medication List | ☐ Psychiatric Progress Notes |
| ☐ Diagnosis | ☐ Discharge Summary |
| ☐ Initial Assessment | ☐ Other: _____ |

SECTION 3 — PREFERRED FORMAT

Select one option below:

- ☐ Paper copy
- ☐ Electronic — CD (available for records maintained in electronic format)
- ☐ Electronic — PDF via secure email (available for records maintained in electronic format)

Copy fees: Paper/hard copy: \$0.37/page (first 50 pages) · \$0.18/page thereafter
Electronic CD: \$5.00 per disc · PDF via secure email: No charge
Search, handling & postage fee: \$10.00 assessed on all requests

SECTION 4 — DELIVERY METHOD

Select one option below:

☐ In-person pickup

☐ By mail

address: _____

☐ By email

address: _____

SECTION 5 — SIGNATURE OF INDIVIDUAL

Signature of
Individual: _____

Date: _____

HAMHDS staff initials (identity
verified): _____

SECTION 6 — IF REQUESTING ON BEHALF OF INDIVIDUAL (complete if different from above)

Name of Person Requesting
Access (print): _____

Phone Number: _____ Mailing
Address: _____

Relationship to Individual (select one):

☐ Parent

☐ Legal Guardian

☐ Authorized Representative

☐ Other: _____

**Signature of
Legally
Authorized
Representative:**_____

Date: _____

**HAMHDS staff initials (relationship
documentation verified):** _____

*Response to Request to Exercise Individual Rights Letter (REC470) must be completed within
30 days of this request.*

Revised 6/24 Form REC469