



## REQUEST TO ACCESS RECORDS & LETTERS

All clients of Community Solutions and/or the Santa Clara County Mental Health Department have the right to inspect or to receive a copy of treatment records. Community Solutions is not required to grant such access, but each request will be carefully reviewed and approved if warranted. You will be notified when your request has been approved or denied, and the reasons for any denial.

### CLIENT INFO:

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

### REQUESTING PARTY INFO:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Primary Phone#: \_\_\_\_\_ Okay to leave messages? YES NO

### REQUEST DETAILS (Documentation being requested):

Time Period of Request: From: \_\_\_\_\_ To: \_\_\_\_\_ Present Entire Record

#### Copies of Records (PLEASE CHECK WHICH RECORDS YOU ARE REQUESTING)

Assessments/Evaluations

Psychiatric Session Notes

Diagnosis Report

Treatment Plans

Medication Log

Other (Specify): \_\_\_\_\_

#### Letters (PLEASE CHECK WHICH LETTER(S) YOU ARE REQUESTING)

Summary of Services Letter

IEP/School Letter

Jury Duty Letter

Emotional Support Animal (ESA) Letter

Work Accommodation Letter

Treatment & Diagnosis Letter

Other (Specify): \_\_\_\_\_

PURPOSE OF REQUEST (PLEASE BE SPECIFIC): \_\_\_\_\_

### METHOD OF RECEIVING INFORMATION:

In-Person Pick-up at the Gilroy Office: 9015 Murray Ave #100, Gilroy CA, 95020

Certified Mail to Requesting Party Address

Secured Email: \_\_\_\_\_

Fax: Name: \_\_\_\_\_ Fax #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Requesting Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*\*DISCLAIMER: No request to access records will be processed unless a client/legal guardian/legal representative has signed the above line, or provided a valid Consent/Authorization to Release Confidential Health Information form, granting the requesting party access. A client's representative needs to provide documentation or explanation of his/her authority to act for the client.*