ADVANCED RECOVERY SYSTEMS
an advanced approach to patient care

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Date Received by ARS: _____ [*ARS to complete*]

Patient to complete the following:

Name:_____ DOB: _____

Email Address: _____

Phone Number: _____

Address: _____

Request:
I hereby request that Advanced Recovery Systems, LLC ("ARS") provide me with access to my Protected Health Information as checked below (check all that apply):

- ☐ Treatment Plans
- ☐ Biopsychosocial Assessment
- ☐ Therapy Notes
- ☐ Entire Record
- ☐ Other (specify): _____
- ☐ Physician Orders
- ☐ Medication Records
- ☐ Discharge Summary

Please specify ARS facility: _____

Please specify requested medical record date range, if applicable: _____

Type of Access Requested:

_____ Inspection of requested information at ARS

_____ Copies of of requested information maintained by ARS

If copies are requested, how should this information be sent (electronic/email, fax, oral, mail)? _____

Patient Signature _____ Date_____

Authorized Representative Signature (if applicable)_____ Date_____

Authority to act for the Patient _____