



Health Solutions West  
Medical Records  
515 28 3/4 Road  
Grand Junction, CO 81501  
Phone: (970) 683-7252

## CLIENT/PATIENT REQUEST FOR RECORDS

\*\* This form is to be completed by a client/patient, or a person legally authorized to act on the client/patient behalf when they are requesting access to their own medical, clinical or business records.\*\*

Date: \_\_\_\_\_ Client ID Number: \_\_\_\_\_  
Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

I wish to access the following types of records:

<input type="checkbox"/> West Springs Hospital	<input type="checkbox"/> Medical Only ( <i>Med Management, Diagnostic Eval</i> )
<input type="checkbox"/> Transitions at West Springs	<input type="checkbox"/> Clinical Only ( <i>Clinical Assessment, Therapy/DAP Notes</i> )
<input type="checkbox"/> Health Solutions West Outpatient	<input type="checkbox"/> Billing/Financial
<input type="checkbox"/> Other _____	<input type="checkbox"/> All Records

Dates of service for requested records: From: \_\_\_\_\_ To: \_\_\_\_\_

This is a standing request to receive updates on my records, good for 6 months:

(*I understand I must notify Medical Records to receive my records*)

Please give a brief explanation for this request:

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When access is granted, how would you like to receive your records?

☐ In Person ☐ Certified Mail ☐ Encrypted Flash Drive ☐ Encrypted Email

Send them to someone else: \_\_\_\_\_

(You must fill out an Authorization for this option!)

*I understand that in very limited circumstances I may be denied the ability to inspect or obtain my records, in whole or in part, because of a potential risk to me or to someone else, or for legally permissible reasons. Medical Records will inform me in writing of any decisions including fees that were made in regards to this records request, the reason for the denial, and the process of review I am entitled to.*

Signature of Requester: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Processing Hours for Records Requests: Mon–Fri 8:30–4:30**

**\*Please allow up to 30 days for Medical Record processing**