



The Center For Health Care Services

### Request For Action Concerning Protected Health Information

Consumer Name: \_\_\_\_\_  
Case #: \_\_\_\_\_  
Program/Unit #: \_\_\_\_\_ Sub-Unit #: \_\_\_\_\_  
Medicaid #: \_\_\_\_\_

SS #: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

I request that The Center for Health Care Services (CHCS):

.....  
**Section I: Provide me (check all that apply)**

- \_\_\_\_\_ a copy of my health information covering the time period described below **(possible fee)**
- \_\_\_\_\_ a summary letter of my health information covering the time period described below **(possible fee)**
- \_\_\_\_\_ access to review my health information covering the time period described below
- \_\_\_\_\_ an accounting of disclosures of my health information covering the time period described below

**Type of Information Requested:**

**Time Period:**

\_\_\_\_\_ **From** \_\_\_\_\_ **To** \_\_\_\_\_

Optional: Copies or access to my health information is for the following purpose (check one):

- \_\_\_\_\_ To assist in disability evaluation
- \_\_\_\_\_ To assist my care provider
- \_\_\_\_\_ To assist in other evaluation and treatment
- \_\_\_\_\_ To assist in educational placement
- \_\_\_\_\_ Other: \_\_\_\_\_

.....  
**Section II: Amend my clinical records as follows: (please indicate if additional pages are attached)**

\_\_\_\_\_

.....  
**Section III: Not disclose my health information to the following persons or organizations:**

\_\_\_\_\_  
\_\_\_\_\_

.....  
**Section IV: Not contact me in the following manner or at the following location:**

\_\_\_\_\_

.....  
**Section V: Contact me in the following manner or at the following location (include e-mail address if appropriate):**

\_\_\_\_\_

\_\_\_\_\_  
Signature of Consumer or Representative

\_\_\_\_\_  
Relationship to Consumer

\_\_\_\_\_  
Date

\_\_\_\_\_ CHCS agrees to the request

\_\_\_\_\_ CHCS does not agree to the request (attach written statement)

\_\_\_\_\_  
Signature of CHCS Professional

\_\_\_\_\_  
Title

\_\_\_\_\_  
ID #

\_\_\_\_\_  
Date

**Return this form to:** The Center for Health Care Services, Attention: Release of Information  
6800 Park Ten Blvd., South Building, Suite 200-S San Antonio, Texas 78213  
Fax: (210) 261-1817 Phone: (210) 261-1074