

**TILLAMOOK FAMILY COUNSELING CENTER
ACCESS REQUEST FORM**

Patient's Name:	
	Last First
Mailing Address:	
	City State Zip
Phone:	
	Date of Birth: _____

I hereby request that Tillamook Family Counseling Center provide:

- Access to **OR**
- A copy of the "Requested Information" checked below:
 - Mental health records
 - Chemical dependency records
 - Billing records
 - Any other personally identifiable information used by Tillamook Family Counseling Center.

Please check ONE of the boxes below:

- I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through _____.
- I am interested in accessing or obtaining a copy of all Requested Information maintained by Tillamook Family Counseling Center.

I understand that Tillamook Family Counseling Center may deny this request under limited circumstances as provided for under state and federal law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law; I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Tillamook Family Counseling who did not participate in the Tillamook Family Counseling Center's decision to deny my request.

