

Letter Request or Records Request

ASAP is legally required to take great care before releasing private health information.

All ASAP clients and parents have agreed on admission to follow the Letter Request/Records Request policy.

This policy requires the ASAP clinical team to confer regarding any request for release of records and decide as a team how we should most accurately describe the progress a client made or is making in the ASAP Program.

After this conference the most appropriate records can be assembled or the appropriate letter can be written.

Parents and clients have agreed that this process takes three to five business days, as determined by ASAP staff, and of course they should inform ASAP staff of their Request as far in advance as possible.

Clinical Records/Letters are not an emergency and are not released without the proper and full completion of this policy.

Parents and clients have agreed to the policy as the best means to ensure that the proper information is gathered and released in the best interests of the client

Letter Request Packet

updated 3-20-07

reminder – 3 to 5 business days are required to hear this request and generate a letter

This Letter Request Packet is used whenever a request for a letter or information of any sort documenting some fact about treatment is made. Parents must complete this Letter Request in order to ASAP to consider generating a release of private health information

The letter needed is for the following ASAP client:

The following person is requesting a letter:

Name of person requesting a letter:

phone number to contact this person

The letter is needed for the following reasons:

We give ASAP permission to write whatever letter, or assemble whatever information, ASAP believes will best and most efficiently meet this need.

The letter should be sent by ASAP staff to:

name

address

city

state

zip

OR Fax number: _____

We understand and agree that the Clinical Staff will determine the appropriateness of sending a letter and the appropriate content of the letter. We have completed the attached Release of Information in order to allow for the release of this information if the ASAP Clinical Team deems it appropriate.

signature of person requesting the letter

date

this form, and the Permission to Release Private Health Information form, can be faxed to ASAP at (480) 704-5550

ADOLESCENT SUBSTANCE ABUSE PROGRAM

Substance Abuse Education, Treatment, and Prevention for Adolescents and their Families
4222 East Camelback, #230H, Phoenix, Arizona 85018
Phone: (602) 434-0249 Fax (602) 996-2448

Permission to Release Private Health Information

Client Name: _____

Client date of birth: _____

Parent name: _____

The parent named above hereby certifies that he/she has proper legal custody and control of the client and authorizes exchange of the information listed below between the ASAP Program and :

Name of individual or organization

The purpose of this release of information is: _____

It is agreed that this information may be shared verbally and/or in writing, as determined by ASAP staff. We are requesting that the information to be released includes the following:

_____ Treatment Summary or Discharge Summary

OR

_____ Other (_____)

It is understood that medical records are protected under federal confidentiality regulations and cannot be released without the permission of the client unless otherwise provided for in these regulations. It is also understood that this Consent expires one year from the date treatment was terminated at ASAP.

Date signed: _____

Parent signature: _____

(client must sign if age 18 or over)