ASAC
AREA SUBSTANCE ABUSE COUNCIL

PREVENT • TREAT • RECOVER

Today's Date: _____

PATIENT REQUEST FOR INFORMATION

**The DOT does not accept copies of records for reinstating a license after an OWI charge, documentation must be sent directly from ASAC. Please contact our office if this is regarding the DOT.*

Patient Information (Please Print)

Last Name:	First Name:	Middle Initial:	Date of Birth:
Phone:	E-mail (optional):		

Street Address:	City:	State:	Zip:

What records would you like? _____

_____

Date(s) that you were involved with ASAC: _____

Why do you need a copy? _____

_____

How would you like your records sent?

- ☐ Picked up by me at the office
- ☐ Emailed to my email address above, via secure email
- ☐ Mailed to my address above
- ☐ Sent to another individual: _____

(A separate consent to release information form will need to be signed for this option)

_____ _____

Signature of Patient **Date**

The Area Substance Abuse Council recognizes a patient's right under HIPAA and 42 CFR Part 2 to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

Per HIPAA regulations, ASAC has 30 days to handle requests for information, as noted on the Notice of Privacy Practices.

FOR OFFICE USE ONLY:

Request Completed On: _____ (Date) Request Completed By: _____ (Staff Name)

Notes: _____