



CEDAR CENTRE

PSYCHIATRIC GROUP, L.L.P.
P.O. Box 1408
Cedar Rapids, IA 52406-1408 (319)-365-3993

Name of Patient _____ Date of Birth ____/____/____

I request that Cedar Centre Psychiatric Group, L.L.P provide me with access to my personal mental health information as checked below:

- Medical Records
- Other (Please indicate if something specific is needed)

Type of Access Requested

- Copies of requested information**
Please specify the manner in which you desire
 - Mailed
 - Faxed
 - Pick Up

Please mail/fax the information to:

- Inspection of my mental health information** at Cedar Centre Psychiatric Group.
(An appointment will need to be scheduled in advance with our records department. Please note that a reasonable amount of time will be given to review the chart, which will be determined by the physician on a case by case basis.)

I understand that there may be a charge for the information that I have requested.
I also understand that the Cedar Centre has 30 days to respond to my written request.

Signature of Patient or Patient's Authorized Representative

_____/_____/_____
Date

Print Name

Relationship