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