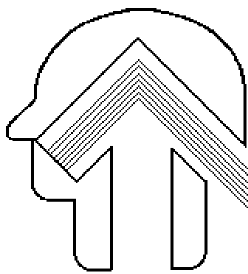

CEDAR CENTRE

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 request.

____ _____/_____/_____
Signature of Patient or Patient's Authorized Representative Date

__________________________________ ________________________
Print Name Relationship

____
Contact Phone #