APPALACHIAN STATE UNIVERSITY
COMMUNICATION DISORDERS CLINIC

REQUEST TO ACCESS INFORMATION

Name:
Address:
Date of Birth:
Phone:

I request access to the following information in my designated record set:

_____
__

_____
__

for the time period from _____ to _____.

I understand that certain information is exempt by law. Under certain circumstances, I may be entitled to a review if my request is denied for certain reasons. I understand that I will be contacted in not less than 30 days after receipt of this request. I may be required to pay reasonable cost-based fees for this information.

___ I would like an appointment arranged for my inspection.

___ I will return for my copies once I am notified.

___ I want my copies mailed to: _____

___ In lieu of inspection or copies, I agree to accept a summary or explanation, and I understand that I will be informed of the fee prior to incurring a fee for preparation.

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____
Client, Parent, or Legal Guardian Date