PRO BONO COUNSELING

Your Mental Health Connection

REQUEST FOR RECORDS

Client Name: _____ **DOB:** _____

Client Address: _____

Phone Number: _____

_____

If the person requesting records is not the client, please complete the below. If not, skip.

Name of person requesting records: _____

Relationship to Client: _____

How this person has a legal right to the records? (e.g., legal guardian, personal representative)

I hereby request that [_____] release a copy of the above-identified client's medical records to include: *(Please check all that apply)*

- ☐ Psychosocial Assessment
- ☐ Psychiatric Assessment
- ☐ Additional Correspondences
- ☐ Therapy Contact/Progress Notes
- ☐ Medication Management Notes
- ☐ Treatment Plans
- ☐ Psychological Reports
- ☐ Other: _____

I request that the records be sent to:

- ☐ Myself
- ☐ Facility/Person:

Name of Contact: _____

Facility/Business Name _____

Phone Number: _____

I request that the above-indicated records be sent via:
(Please choose one option, email is preferred)

- ☐ Email: _____
- ☐ Fax: _____
- ☐ Address: _____

_____

I fully understand this request to release records, including the nature of the records, their contents, and the possible consequences and implications of their release.

Signature of Client: _____ **Date:** _____

Signature of Authorized Party: _____ **Date:** _____

Signature of Witness_____ **Date:** _____