REQUEST TO ACCESS RECORDS

This form is to request copies of one's own records. To request to have your records sent to a third party, complete an "Authorization to Disclose Protected Health Information."

Name: ______________________________ Other name used: _________________________

DOB: _______/_______/________ Phone: ______________________________

How would you like to receive the records? (check one option)

___Certified mail; Provide address: ____

___ Pick up at practice office; Provide practice location: ______________________________

Records Requested (check all that apply):

___ Packet (includes Assessment, Treatment Plan, and Notes). *No fees.*

___ Full record. *May include additional fees*.

___Other records wanted: ______________________________________

Dates Requested:

___ From (date): _______ To (date): _______

___ All dates of service

Provider(s): ______________________________________

Provider(s): ______________________________________

Client Signature: __________________________________ Date: _______________

Print Name: ______________________________________

If client's personal representative:

Signature: ____ Date: _______________

Print Name: ____

Relationship to client: ______________________________________

Copyright 2020 Between Sessions Resources