



RECORDS REQUEST

Records Requestor:			
Name: Last		First	Title(if applicable)
Organization or Business Name (if applicable)			
Mailing Address		City	State Zip Code
Telephone Number (include area code)	Fax Number (include area code)	E-Mail Address	
Relationship to Records: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Behavioral Health Provider <input type="checkbox"/> Medical Provider <input type="checkbox"/> Attorney <input type="checkbox"/> Other: _____			
(You may be asked to produce proof of identity to obtain confidential records. The client must also sign an "Authorization for the Release of Information" form indicating specifically what information may be released, to whom, and by what method.)			
Client Information:			
Name: Last		First	Date of Birth
Former Names:			
Requested Documents. NOTE: Be specific as possible so your request can be processed accurately. Please include dates (time frames) and specific documents (i.e mental health assessment, psychiatric assessment, safety crisis plan, education records, health records, discharge summary)			
Requestor Signature			Date
Office Use Only:			
Date Received	Compliance Officer Name		Date Records Distributed
ROIs Verified	Records Distributed		
<input type="checkbox"/> Yes <input type="checkbox"/> No			