PRO BONO COUNSELING

Your Mental Health Connection

REQUEST FOR RECORDS

Client Name: ______________________________ **DOB:** ________________

Client Address: ____

Phone Number: ____

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

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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:** ______________