Osage Valley Counseling LLC
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Request for Medical Records

(Email completed form to admin@osagevalleycounseling.com)

Name of Client: ____ Date of Birth: ___ / ___ / ________

Address: ____

Phone: ____________________________ Email: ____

Request Details

Type of Records Requested: ▢ Counseling Progress Notes* ▢ Psychosocial Assessment ▢ Treatment Plan

▢ Other (Specify): ____

Date Range of Records being Requested: From _____ / _____ / __________ to _____ / _____ / __________

Purpose of Request: ▢ Personal Copy ▢ Legal Proceedings ▢ Insurance Claims ▢ Continuity of Care

▢ Other (Specify): ____

Authorization for Release

I, the undersigned, authorize Osage Valley Counseling, LLC to release the requested medical records to me or the third party specified below.

I acknowledge that the release of any information pertaining to substance use is further protected by regulations outlined in CFR 42 Part 2. By checking the box below, I authorize the release of substance use information as part of this medical records request should my record include such information.

▢ I authorize the release of substance use information under CFR 42 Part 2.

Recipient's Name/Organization (if going to a third party): ____

Address of Recipient: ____

Phone Number of Recipient: ____

Email of Recipient: ____

Preferred method of sending medical records: ▢ US Mail ▢ Secure Fax ▢ Email (not HIPAA compliant)

▢ Recipient will pick up records in person (coordinate a day/time with administrative assistant)

Client/Guardian Signature: ____ Date: ____ / ____ / _________

FOR OFFICE USE ONLY

Date Received: ____ / ____ / ________

Processed By: ____

Records Sent on ____ / ____ / ________ by means of ▢ US Mail ▢ Secure Fax ▢ Email ▢ In Person Pick Up