



Request to Access Your Record

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

Last Name: First:

Other Names used:

DOB: ____/____/____ Phone: _____

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

Mailed (Certified) Address: _____

Pick up at Clinic Clinic location: _____

Records Requested (check all that apply):

Packet (includes Assessment, Treatment plan, and Notes. No fees)

Full Record set (may include additional fees)

Other records wanted:

Specify: _____

Dates of Service:

Date From: ____/____/____ Date to: ____/____/____

All dates of service:

Provider(s):

Provider(s): _____

Patient/ Personal Representative

Signature: _____ Date: ____/____/____

If personal representative:

Print Name: _____

Relationship to client: Parent- Guardian-