DLB Counseling & Consulting, LLC
4905 N. Union Boulevard, Suite #200
Colorado Springs, CO 80918
Phone: 719-459-9928 Fax: 719-452-3928
www.dlbcounseling.com

Mental Health Records Request Form

Date Requested: ___/___/___

Client's Name (First, Middle, Last): _____

SSN: _____-_____-_____ Birth Date: ____/____/____

Address (City, State, ZIP): _____

Requested by: ☐Client ☐ Other (Name & Title) _____

Please Note: DLB Counseling & Consulting, LLC will require up to **30** days for locating and producing a copy of your requested mental health records. Fees must be paid upon the request of the records. ***If a records request is made from an outside agency/source DLB Counseling & Consulting, LLC requires a signed release of information form from the client.***

Document(s) Requested
☐ Records Request (see fee schedule below)
☐ Treatment Summary **($85.00 fee**)

Delivery Method and Fees (Select **ONE** method of delivery below-Electronic, Hard Copy, U.S. Mail, or Fax**)**

☐ Electronic *The designated information about me* ☐ ***may*** ☐ ***may not*** *be transmitted by fax, electronic mail or other electronic file transfer mechanisms.*

☐ Email (Fee **$35.00)**: Records can be emailed except in the limited case where e-mail cannot accommodate the file size.

☐ USB drive (additional **$5.00**)

Email address: _____ @ _____

☐ Fax (Fee **$35.00)** Fax Number: (_____)_____

☐ Paper Copy
$18.53 flat fee (first ten pages)
$0.85 (pages 11-40)
$0.15 (each additional page after page 40)

☐ U.S. Mail (Additional fees apply for postage)
Address (City, State, ZIP):_____

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I limit the information to be released to the following items: (Please check specific items)

☐Progress/Treatment Reports	☐ Entire Mental Health Record	☐ Treatment Summary (**Fee $85.00**)
☐Discharge Summary	☐ Diagnosis	☐ Course of Treatment
☐Attendance	☐Treatment Plan	☐ Progress Notes
☐Psychological/Medical	☐ Entire Mental Health Record	☐ Other (Please Specify):

Purpose of disclosure/why information required:

☐ Coordination of Care	☐Transfer of Care	☐ Medical Care
☐ Billing/Claims	☐ Legal Issues	☐ Consultation
☐ Ongoing Treatment	☐ Evaluation	☐ Health Benefit
☐ Other (Please Specify):		

Signature: _____ Date: ___/___/___
Patient (Parent or Guardian if patient is a minor)

Minor's signature is required for release of any records for threat that the minor may have authorized.
RELATIONHIP (if other than patient): _____

☐

Please circle card used: Visa Mastercard Discover AMEx HSA Other	
Card Number	CVV Code
Signature	Exp. Date
Amount Due $	Amount Paid $

Make Check Payable To
DLB Counseling & Consulting 4950 N. Union Blvd., Ste. 200 Colorado Springs, CO 80918