Vance Mental Health Services
601 Post Office Road
Suite 2B
Waldorf, MD 20602
(301) 868-0461 Fax (301) 885-0922
info@vancementalhealth.net

Office Use Only	**Received on: _____ / Completed on: _____** **__ ROI on file - ___ROI Not on file // Requesting to be ____Mailed - ___ Faxed - ___Emailed** **Tracking Number:_____**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please complete this form in its entirety so we can help you receive the information you are requesting.

Patient Name: _____ Maiden//AKA_____DOB_____
Street Address: _____ City/State/Zip_____
Primary Phone: _____ ___Home ___Work ___Cell ___Other _____
Alt Phone: _____ ___Home ___Work ___Cell ___Other _____
Email Address:_____

I, the patient or legal authorized representative, authorize VMHS to release my protected health information to:

___ Myself ___ Other
Individual/Person*_____Company/Organization:_____
Street Address: _____ City/State/Zip_____
Telephone #:_____ Fax: _____
Email address: _____

Select Delivery Method: ___eDelivery ___ US Mail ___Pick-Up from Office

If this request is to send records to another health care provider, please initial and list speciality, so that we may update your chart.
Speciality:_____ Initials: _____

Please include:
___Written Documentation (includes assessments, provider notes, clinical/discharge summary, consults and test reports)
___Billing Invoices
___Other Records: _____

From Dates of Service _____/_____/_____ to _____/_____/_____
___Present or ___All Treatment Dates

Specific Information to be disclosed:

___Verbal Exchange of Information
___Presence in treatment, Prognosis, Brief Description of prognosis, Occurrence of relapse
___Medical Social History, Intake, Treatment Plans, Psychiatric/Psychological Evaluations, Progress, and Discharge Summary
___Release of documentation (including letters, records, and the like) to the above named individual.

Purposes of release/disclosure:

___ Continuation/Transfer of Care ___ To obtain insurance, employment of government benefits
___To provide disability determination ___To coordinate treatment efforts with my family/concerned persons
___Legal Representation; to enable judges, attorneys, probation/parole officers to support treatment goals.

Records set to be released to the party(s) indicated above:

I request the following information to be released, which may include: alcohol and drug abuse/treatment, psychological and social work counseling; HIV, AIDS, or ARC; communicable disease or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, genetic information and demographic information for the purpose and conditions designated.

This authorization is voluntary. I understand that Vance Mental Health Services (VMHS) will not base treatment, payment, enrollment, on my signing this document. I am aware that this authorization expires on ____/_____/____, and that if left blank, the authorization will expire 60 days from the signature date. I understand that I may cancel/revoke this authorization at any time in writing. All revocations must be mailed to Vance Mental Health Records, Medical Records, at the address listed above. Please note that once information is disclosed, VMHS can no longer protect it from further disclosure.

_____ _____/_____/_____
Signature of Patient or Authorized Rep (if minor, or unable to sign) Date: (mm/dd/yyyy)

_____ _____/_____/_____
Printed Name of Patient or Authorized Rep (if minor, or unable to sign) Date: (mm/dd/yyyy)
Relationship to Patient (if other): ____Spouse ___ Parent ___Next-of-kin ___Legal Guardian

____Check here if you require a call or fee approval prior to us processing your records.

Additional Information Regarding Your Request

Requesting medical records on behalf of another person:

If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record. Examples of these documents include but are not limited to: letters of representation, guardianship papers, affidavit of heir at law, etc… Please contact us with any questions regarding the process.

Submitting requests and receiving record copies - requests for medical records may be:

- Mailed to Vance Mental Health Services, Medical Records, 601 Post Office Road, Suite 2B, Waldorf, MD 20602
- Faxed to Vance Mental Health Services at (301) 885-0922; **ATT: Medical Records**
- Submitted in Person - Monday thru Friday between 9:30 am and 3:30 pm at 601 Post Office Road, Suite 2B, Waldorf, MD 20602

Due to large volumes of medical records requests, **our average time for processing records is seven to ten business days, plus shipping time**. However, they will never exceed twenty-one days unless otherwise communicated. If you have not noted how you would like your forms to be released, they will be sent through USPS by default. Records needed for medical emergencies will be faxed directly to a physician or other medical facility. Please be sure to include your phone number on your request in case we need to contact you for additional information. Some records requested for legal, insurance, or personal use may require prepayment. If your request requires prepayment, a fee invoice will be sent to you upon the processing of your request.

Our processing fees for medical records are as follows:

$22.88 Processing Fee
$.76 per page plus S&H