

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

Office Use Only	Received on: _____ / Completed on: _____ __ ROI on file - __ ROI <u>Not</u> on file // Requesting to be ___ Mailed - ___ Faxed - ___ Emailed Tracking Number: _____
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**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: _____
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**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 - hard copy of file

\$6.50 for electronic copy only