Osage Valley Counseling LLC
Ph: (636) 600-0446
Fx: (636) 660-2262
www.osagevalleycounseling.com

1736 Westpark Center Dr. #100, Fenton, MO 63026
320 Gravois Rd. #210, Fenton, MO 63026

info@osagevalleycounseling.com

Request for Medical Records

(Email completed form to management@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