

# Turning Leaf Counseling

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## Request for Records Form

Authorization for release or request of medical records:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

E mail Address \_\_\_\_\_

I authorize *Turning Leaf Counseling, Inc* to release, disclose, or request confidential health information about me, by releasing or requesting a copy of my medical records, a summary or narrative of my protected health information, or verbally to the individual or organization listed below.

I am requesting that my medical records be released to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax: \_\_\_\_\_

Please release the following information:

\_\_\_ Evaluation/Assessment

\_\_\_ Progress Notes

\_\_\_ Treatment Plan

\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
Signature or Individual's Legal Representative

\_\_\_\_\_  
Date