Name of Client/Patient Date of Birth (mm/dd/yyyy) Phone Number

Address City, State, Zip

I am requesting a copy of my records from       /       /       to       /       /      .

I am requesting to review or copy the following information:

Please check all that apply to your request:

[ ]  I am requesting access to review my records.

[ ]  I am requesting paper copies of my records be prepared for my pick-up.

[ ]  I am requesting paper copies of my records be mailed to me at the following address:       .

[ ]  I am requesting paper copies of my records be sent on my behalf to the following address:       .

[ ]  I am requesting electronic copies of my records be sent on my behalf to the following email address:       .

Signature: Date:

If this form is completed by a parent/guardian/authorized agent on behalf of the client/patient, complete the following:

Parent/Guardian/Authorized Agent’s Name (please print)

Please check one of the following:

[ ]  Parent/Guardian

[ ]  Authorized Agent

|  |
| --- |
| For Office Use Only If Records Requested to be Inspected:Name of Inspecting Person:       Records Released for Inspection:        |