SouthernMED COUNSELING

RECORDS REQUEST FORM

Patient's Full Name:_____

Patient's DOB:_____ Phone:_____

Medical Records From:	**Medical Records To:**
_____	_____
Name of Facility	Name of Facility
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone Number	Phone Number
_____	_____
Fax Number	Fax Number
_____	_____
Email (if applicable)	Email (if applicable)

Please indicate which items from the record you are requesting:

☐ Entire record
☐ Discharge Summary
☐ Evaluation Results/Summaries
☐ Correspondence with others involved in care
☐ Individualized Education Plan
☐ Psychological Testing/Results Summary
☐ Treatment Plans/Updates
☐ Recommendations
☐ Progress Summaries
☐ Appointment/billing records
☐ 504 Plan
☐ Diagnoses
☐ Intake Paperwork
☐ Assessments
☐ Safety Plan
☐ Medical Report

☐ Psychotherapy Case Notes Summary Letter*

☐ Other_____

Time Period: From:_____ To: _____

*It is SMC's policy to supply Case Note Summary letters rather than release raw case notes.

The Purpose of this Request:

☐ Planning Appropriate Treatment or Program
☐ Referral/Transfer of Case
☐Update Files
☐Other: _____
☐ Coordination of Services

Expiration:

This release shall be in force and effect until the time or event specified below, at which time this release expires:

____ 1 year from signature date ____Child turns 18 years old ____Other: _____

Please indicate how you would like the records delivered:

☐ Mail – To:_____

Address:_____City:_____State:_____Zip:_____

☐ Fax- #_____ ☐ In person at SMC

☐ Other _____

I hereby authorize the use or disclosure of my protected health information as specified above. I agree to allow SouthernMED Counseling (SMC) a reasonable period of time to verify the validity of your request and prepare copies of the records if authorized by the above client/personal representative. Also, I acknowledge that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of Protected Health Information that may be beyond SMC's control. I agree to hold SMC harmless in the event the requested Protected Health Information is breached or compromised as a result of directing and authorizing(if applicable) SMC to transmit or deliver such information electronically. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of office staff. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.

_____ _____ _____

Signature of Patient or Personal Representative Date Relationship of personal representative to patient

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:	**Released by:**
Date Received:	**Date Released:**
ROI Signature Date:	**Comments:**
Staff Signature:	**Staff Signature:**