REQUEST FOR MEDICAL RECORDS

Client Name: _____ **DOB:** _____

Client Address: _____

Therapist's Name: _____ **Date of Last Appointment:** _____

IF THE PERSON REQUESTING RECORDS IS NOT THE CLIENT, PLEASE COMPLETE BELOW.

Name of person requesting records: _____

Relationship to Client: _____

How this person has a legal right to the records? (e.g., legal guardian, personal representative)

I hereby request that Imara Counseling Services release a copy of the above-identified client's medical records to include:

(Please check all that apply)

- ☐ **Psychosocial Assessment** ☐ **Therapy Contact/Progress Notes** ☐ **Treatment Plans**
- ☐ **Psychiatric Assessment** ☐ **Medication Management Notes** ☐ **Psychological Reports**
- ☐ **Additional Correspondences**
- ☐ **Other:** _____

I request that the records be sent to:

☐ **Myself** ☐ **Facility/Person**

Name of Contact: _____

Facility/Business Name: _____

Phone Number: _____

I request that the above-indicated records be sent via:

(Please choose one option, email is preferred)

- ☐ **Email:** _____
- ☐ **Fax:** _____
- ☐ **Address:** _____

I fully understand this request to release records, including the nature of the records, their contents, and the possible consequences and implications of their release.

Signature of Client: _____ **Date:** _____

Signature of Authorized Party: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____