Behavioral Health Records Request Instructions

A records request is a request for specific medical records related to your treatment. The request will release specific medical information to an individual or entity that is authorized. We will do everything in our ability to protect your information. However, it is important to understand by completing the form there is risk that information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA. A fee may also be assessed.

1. **Client Information**

Information is for the person whose records are being requested. Name and date of birth are required. Parent/Guardian information should be included as well as the relationship to the patient.

2. **Release Purpose**

Please check the box with the reason the information is being released. If the reason is not listed, please specify.

3. **Information to be Released BY**

This is the Organization or Person who is releasing the information, and must include a specific and complete address, phone number and/or fax number in order for the request to be processed.

4. **Information to be Released TO**

This is the Organization or Person that will be receiving the requested information, and must include a specific and complete address, phone number and/or fax number in order for the request to be processed.

5. **Delivery of Information**

Please initial the box next to how you want your records delivered (i.e. by mail, fax, email, etc.). If you would like us to email the documents an Electronic Communication Consent form is also needed.

6. **Records to be Released**

Indicate the specific dates / timeframe you want records released from. Check off the type of records to be released. Indicate if Substance Use Disorder Treatment records are to be released and what specific records are to be released.

7. **Signature(s)**

All requests must be signed and dated. Parent/guardians must sign and date this form for minors under the age of 14. Please note that if the child is under 14, and both parents have legal custody, a Records Request and Release of Information is required from both parents before a Records Request can be processed.

Behavioral Health Records Request

Please read all information and instructions before completing and signing the authorization form.

1. CLIENT INFORMATION

Patient Name:_____ DOB:_____

Parent/Legal Guardian Name (if applicable):_____ Relationship to patient: _____

2. RELEASE PURPOSE

☐ Personal ☐ Transfer of Care ☐ Disability ☐ Insurance ☐ Legal
☐ Continuing Care ☐ Other (please explain): _____

3. WHO DO YOU WANT TO RELEASE YOUR INFORMATION?	4. WHO DO YOU WANT YOUR INFORMATION GIVEN TO?
Check one box and complete, if applicable. ☐ **The Family Connection and its affiliates** ☐ **Other,** specify organization, department or individual **REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER** Organization/Person Name Street Address City State Zip Code Phone Fax	Check one box and complete, if applicable. ☐ **The Family Connection and its affiliates** ☐ **Other,** specify organization, department or individual **REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER** Organization/Person Name Street Address City State Zip Code Phone Fax
Unless otherwise revoked, this authorization will expire on the following date:_____. If left blank, this authorization will expire one year for the date signed.	

5. DELIVERY OF INFORMATION

_____US Mail (address listed above)
_____FAX (number listed above)
_____Electronic via secure email (list email address)_____[ECC required]
_____Pick-up at The Family Connection location (please specify location) _____
_____Other, specify _____

6. RECORDS TO BE RELEASED

Timeframe to Be Released

FROM_____(mm-dd-yyyy) TO_____(mm-dd-yyyy)

Type of Records (check all that apply)

☐ Complete Record ☐ Treatment Plans ☐ Billing Information ☐ Assessments ☐ Diagnosis(es)
☐ Appointment dates/times ☐ Discharge Summary ☐ Progress Notes ☐ Other, specify

Substance Use Disorder Treatment (SUD) Records (check all that apply) ☐ DO NOT RELEASE SUD RECORDS

☐ Complete Record ☐ Treatment Plans ☐ Treatment Progress/Outcome ☐ Treatment Outcome
☐ SUD Assessments ☐ Compliance/Non-compliance with Treatment ☐ Progress Notes
☐ Appointment dates/times ☐ Discharge Summary ☐ Aftercare Plan ☐ Other, specify _____

THE FAMILY CONNECTION™
CHANGING MENTAL HEALTH

7. SIGNATURE AND DATE *Required*

- **I recognize that a valid Release of Information (ROI) is required in collaboration with this Records Request.**
- This authorization may be revoked at any time except to the extent that the agency has already taken action in reliance on it. You may revoke this authorization by providing the Request to Revoke Release Authorization form to the appropriate department.
- I understand that the information to be released includes behavioral and/or mental health care records and could include records related to HIV/AIDS, communicable diseases and/or treatment for alcohol or substance use disorder.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- I may request a copy of this signed Records Request.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.
- I understand that a request for records does not guarantee that the records will be released, in accordance with Federal and State Laws that prohibit unauthorized disclosure of these records.
- I recognize that for **MINORS AGE 14-17:** A minors patient's signature is required in order to release information related to the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 14 and older), and (3) mental health conditions (age 14 and older).

Patient signature *(required)*:	Date *(required)*:
Printed Name of Person Signing (First, Middle, Last):	
Parent/Legal Guardian Signature:	Date:
Printed Name of Parent/Legal Guardian Signing (First, Middle, Last):	

Relationship to Client: ☐ Parent ☐ Legal Guardian ☐ Legal Authorized Representative

NOTE: If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form for ALL Legal Guardians.

INTERNAL USE ONLY

1. Received By:_____On: _____
2. Sent to HIM Dept. By:_____On:_____Via ☐ Email ☐ Other _____
3. Initial Review: By:_____On: _____
4. HIPPA Checklist Completed By:_____On: _____
5. Return to Requestor By:_____On:_____Return Letter Date:_____☐ N/A
6. Document(s) eligible for release – Sent to Clinical Director_____for Review By:_____On: _____
7. Document(s) released in accordance with scope of patient request By:_____On: _____