

**Client/Legal Guardian - Request for Records Form**

Date of request: \_\_\_\_\_

Clinic Location: \_\_\_\_\_

Please indicate if you are requesting as:    Self    Legal Guardian\*    Non-Custodial Parent\*\*

I, \_\_\_\_\_, am requesting a copy of the specific mental health information as **indicated** below regarding (name of client) \_\_\_\_\_,  
(birth date) \_\_\_\_\_.

Assessments

Discharge Summary

Treatment Plans

Psychiatric Evaluation by LMP

Progress Notes

Medication Management Notes

Diagnosis Information

SUD Specific Services (please note these require a  
Release of Information signed by the client)

Therapist assigned: \_\_\_\_\_

These records are being requested for the following purpose:

\_\_\_\_\_  
How would you like to receive the records?    Pick Up at Clinic    U.S. Mail    Fax    Secure EmailAddress/Fax/Email where records should be sent:  
\_\_\_\_\_\_\_\_\_\_  
Print Name\_\_\_\_\_  
Relationship to client

Signature: \_\_\_\_\_

\*Parents/legal guardians may be asked to show proof of identity.

\*\*If you are a non-custodial parent to the minor child whose records you are requesting, please provide a copy of the legal document outlining custodial rights.

**FOR OFFICE USE ONLY:**

Request Received By: \_\_\_\_\_

Date records released: \_\_\_\_\_    Staff releasing the records: \_\_\_\_\_