



Family Behavioral Health  
**Records Request Form**

Date Form was submitted:

Preferred Delivery:

- Pick Up
- US Mail

**Part A: Requestor Information (Your Details)**

**FBH Use Only**

ID Verified:  Scanned

Last Name:		First Name:		M.I.:
Address:			Phone Number:	
City:	State	Zip Code:	Fax/Email (Optional):	

**Part B: Client Information**

Last Name:		First Name:		M.I.:
Date of Birth:				

**Part C: Documentation Being Requested** *Excluded: Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. See 45 CFR 164.524(a)(1)(i) and 164.501.*

**Part D: Release To**

Full Name (Write "SELF" if same as Part A):		Agency/Office Name (if applicable):		
Address:		Phone Number:		
City:	State	Zip Code:	Fax/Email:	

**Part E: Policy & Authorization**

A copy of records requested may take up to 30 business days to process, if all the information included in this form is correct. If any of the information in this form is incorrect, it may delay the process. If you would like the records sent via US mail, it may take longer for the records to arrive and will require an additional fee for postage. Cost per page printed is .25 cents per page and is to be paid in full in order to receive the documentation request. Payments accepted are: Cash or debit/credit card. By signing this form, you confirm that you have the authorization to request these records. If you are a guardian of a minor and are involved in any legal matter (Court Mandated Custody etc.) it is required that you provide legal documentation to show evidence of legal rights over the minor of whom you are requesting documentation for.

I hereby consent that I have read and understood the above policy.

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

**For FBH Office Use Only Date Received:**

Disposition: <input type="checkbox"/> Delivered <input type="checkbox"/> Denied <input type="checkbox"/> Unavailable	Disposition Date:
---	-------------------

If request is denied or records are unavailable, please explain here. Attach additional pages if necessary.

Print Fee Amount Collected: \$	Client Initials Confirming Amount Received:
Print Fee Amount Actually Used: \$	
Print Fee Amount Refunded: \$	

**PLEASE RETURN FORM TO THE FRONT DESK**