

Hope Performance Systems LLC

Client Request to View Records

Client Information

Client Name:

Address:

City/State/Zip:

Phone:

Ok to leave message

Social Security Number:

Date of Birth:

Please explain why you are requesting these records:

Dates of Service you are requesting:

I am requesting my records between the dates of _____ and _____

Information to be RELEASED:

Check all that apply:

Counseling Record and Notes

Listing of dates of treatment

Psychiatric Records and Notes

Addictions Assessment

Financial records pertaining to treatment, services received, and/or goods purchased from a period of _____ to _____

Other: _____

Other:

I have read and understand the following:

- 1) Copies of my record will be charged at \$.15 a page, payable in advance;
- 2) It will take approximately two weeks to process my request. This is because the record must go through a clinical re-view process to determine if it is in the best interest of myself or the client's (in cases where the client is a minor and/or I am their legal guardian) that the record be released;
- 3) My request may not be granted due to concerns that the information may be harmful or damaging to myself and/or the client;
- 4) Due to the highly sensitive nature of these records, I may also be required to make an appointment with my counselor to review my record in person so that she/he can be present to provide information and answer questions I have about the record.
- 5) Should the clinical reviewer believe that the record should not be released to me, the record will be reviewed by a clinical review group made up of masters level mental health professionals and a physician. Should they agree that the record not be released, I understand that it is my right to pursue legal means to gain access to my record.

Name of Client:

Witness Signature:

Signature of client/legal
representative:

Date:

Date of Request:

If you are the legal representative of the person listed above, please check off the basis for your authority:

Power of Attorney (attach copy)

Parent of Minor

Guardianship Order (attach copy)

Other:

Hope Performance Systems LLC

**FULLFILLMENT RECORD
FOR OFFICE USE ONLY**

Address, Email, Fax number to where approved records are to be sent:

Name:

Address:

City/State/Zip:

Phone:

Fax Number:

Email Address:

Detail of records being released or reason for records request denial:

Method of Request Fulfillment:

Records Sent By:

Mail

Fax

Office Pickup

Provided Envelope

Other: _____

Other Information:

Billing Information:

Name of Party Responsible for Records Request:

Address:

Number of Pages Sent:

Amount Billed

Billing Not Required

Signature of Individual
Approving Records:

Date:

Signature of Individual
Sending Records:

Date Record Sent: