

Medical Records Request Form

**Client/Patient
Name:** _____

**Date of
Birth:** _____

Date: _____

**Full Name of
Parent/Guardian Making the
Request (if applicable):** _____

Records Requested

- ☐ **Assessments/Evaluation Results:** Formal evaluations completed for a specific diagnosis. This does not include therapy session notes.
- ☐ **Complete Medical Records:** All available records related to your care, including evaluations, treatment, and clinical documentation.
- ☐ **Treatment Summary of Records:** A brief overview of care; may include diagnoses, progress, and clinician impressions.

Reason for Request (select all that apply)

- ☐ **Disability/Benefits**
- ☐ **Insurance Claim**
- ☐ **Legal Matter**
- ☐ **Personal Use**
- ☐ **School or Workplace Accommodation**
- ☐ **Transfer of Care**

Preferred Method for Receiving Records

- ☐ **Fax**
- ☐ **Client Portal**
- ☐ **Pick-Up In Person**

Delivery details for selected method:

Recipient name, fax number, or other applicable delivery information.

Acknowledgment and Certification

- ☐ I understand that processing may take a reasonable amount of time, including up to 10 business days.
- ☐ I understand that fees may apply as permitted by law.
- ☐ I understand that the records I receive may contain sensitive or confidential information.
- ☐ I understand that once records are released, they may no longer be protected by applicable privacy laws.
- ☐ I certify that I am authorized to request and receive these records.

Printed Legal Name: _____

Signature: _____

Date: _____

Relationship: ■ Self/Patient ■ Parent/Guardian ■ Authorized Representative