SEQUOIA
Mental Health Services, Inc.

RECORDS REQUEST FORM

Date of Request: _____ Attempt Number: _____

MEDICAL RECORDS FROM:	MEDICAL RECORDS TO:
AGENCY NAME	AGENCY NAME
ADDRESS	ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
PHONE NUMBER	PHONE NUMBER
FAX NUMBER	FAX NUMBER
EMAIL (IF APPLICABLE)	EMAIL

INDIVIDUAL

INDIVIDUAL FULL NAME _____ INDIVIDUAL'S DOB _____

- ☐ **Signed Release of Information Attached**
- ☐ **Under HIPAA (45 CFR § 164.506), a Release of Information (ROI) is not required to release protected health information (PHI) for treatment purposes, including continuity of care.**

Please release the following records:

- ☐ Psychiatric/Mental Health
- ☐ Physical Health
- ☐ Lab Reports
- ☐ Urinalysis (Including Substance Use Info)
- ☐ Medication Information
- ☐ History and Assessments
- ☐ Progress Notes/Visit Notes
- ☐ Other: _____
- ☐ Financial
- ☐ Legal
- ☐ Discharge Summary

Time Period Requested: _____ to _____

We appreciate your prompt assistance in this matter. Please confirm receipt of this request and the estimated time frame for fulfillment.

SIGNED _____ TITLE _____ DATE _____

Confidentiality Notice: The information requested is for authorized purposes only and will be handled in compliance with all applicable privacy and data protection regulations. It will be securely stored, accessed only by authorized personnel, and used strictly for the intended purpose of facilitating necessary services for the client. Unauthorized disclosure or misuse of this information is strictly prohibited. If you have any questions, please contact us before proceeding.