CLIENT REQUEST FOR HEALTH INFORMATION

Client Information. ***Please PRINT legibly. All sections of this form must be completed.***

First Name: 1 Last Name: 2 M.I.: 3

Address: 4
Street Address City State Zip Code

Phone Number: 5 Date of Birth: 6

What records are you requesting? *Check appropriate boxes.*

Date(s) of Service: ___7___/_____/_____ through ___8___/_____/_____

9

- ☐ Intake Assessment ☐ Discharge Summary ☐ Treatment Plan ☐ Lab Results ☐ Medication List
- ☐ Assessments ☐ Progress Notes *(limited to individual Case Management/ Therapy/ Dr's notes)* ☐ HIV Info
- ☐ Designated Record Set *(includes above records plus Nurse/ Group/ Administrative progress notes & other items applicable for release)*
- ☐ Billing Records ☐ Other *(please specify)*: 9a

Where would you like this information sent? *Check one box.*

10

ReDiscover should provide my records to: ☐ Self / Legal Guardian ☐ Designated Recipient *(specify below)*

Name / Organization: 11

Address: 12
Street Address City State Zip Code

Phone Number: 13 Relationship to Client: 14

15 **Is this limited to a one time request?** *Check one box.* ☐ Yes ☐ No

If 'No', expires on date / event: 15a *(If blank, expires one year after the date signed.)*

How would you like your records delivered? *Check one box.*

16

Paper: ☐ US Mail ☐ Self Pickup (*specify **ReDiscover** location*): 16a

Electronic: ☐ CD ☐ Email to: 16b ☐ Fax to: 16c

Please sign and print your name below.

17 Client / Legal Guardian Signature

18 Date

19 Client / Legal Guardian Printed Name

20 If other than self, relationship to Client

ReDiscover *recognizes a client's right under HIPAA to access copies of his / her medical information and/or have their medical information explained to them. There may be charges associated with processing a request and producing copies of requested records.*

Please return completed form to: ***ReDiscover*** Attn: HIM, 1555 NE Rice Road, Lee's Summit, MO 64086 ***OR***

Email: medicalrecords@rediscovermh.org ***OR*** **Fax:** (816) 554-5551 **Questions?** Please call (816) 554-5509

For HIM use only:	**SCANNING STAMP**	**MR #:**
Date received: _____		
Initials of Staff Receiving: _____		
Initials of Staff Completing: _____		
☐ *Approved* ☐ *Denied* *Date:*		

REDISCOVER

CLIENT REQUEST FOR HEALTH INFORMATION – USER GUIDE

Purpose: For client / legal guardian to request copies of medical records to be sent to themselves or someone else.

Directions: Follow each numbered blank to complete the form.

1. Client's first name.
2. Client's last name.
3. Client's middle initial (if applicable).
4. Client's current street address, city, state, and zip code.
5. Client's best phone number.
6. Client's date of birth. Please include month, date, and year.
7. Beginning date of records you are requesting. (MM/DD/YYYY)
8. Last date of records you are requesting. (MM/DD/YYYY)
9. Check the boxes of the records you are requesting
   a. List any needed records if they are not listed in #9 above.
10. Check **ONE** box to specify who ***ReDiscover*** is providing the records to.
    - If you select **Self / Legal Guardian**, complete blanks #12-15 below ***ONLY IF*** address and phone number are different than blanks #4-5 above.
    - If you select **Designated Recipient**, you must complete blanks #12-15 for the recipient of the records.
11. Full Name of Recipient or receiving Organization.
12. Recipient's street address, city, state, and zip code.
13. Recipient's phone number.
14. Recipient's relationship to the client.
15. Check **ONE** box to specify if this form is limited to a one time only request.
    a. If you select **No**, specify the expiration date of this form. If this is left blank, the form will expire one year from the signature date.
16. Check **ONE** box to specify how you would like your records delivered.
    a. Specify the ***ReDiscover*** location from which you wish to pick up your printed copies. ***OR***
       (Records will be held for up to two (2) weeks at that front office for pick-up. If you do not pick up the records within two (2) weeks of notification, the records will be sent back to the HIM office*).
    b. Specify the E-Mail address you wish the records to be securely emailed to. ***OR***
    c. Specify the fax number you wish the records to be faxed to.
17. Signature of the client or legal guardian who can authorize this request
18. Date of the signature.
19. Print the name of the signer shown on #17.
20. If client is not the signer, specify the signer's relationship to the client.

Please visit www.rediscovermh.org/client-resources/office-visit-forms/ for FAQ on Requesting Medical Records.