SNBCare
Spectrum Neuro Behavioral Care

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 to

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 review 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)
- ☐ Guardianship Order (attach copy)
- ☐ Parent of Minor
- ☐ Other:

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FULFILLMENT 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:

Signature of Individual Sending Records:

Date: 11/02/2021

Date Record Sent: 11/02/2021

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