

REQUEST FOR HEALTH INFORMATION

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

First Name: _____	Last name: _____	M.I.: _____
Address: _____		
Street Address	City	State Zip Code
Phone Number: _____	Date of Birth: _____	

What records are you requesting? Check appropriate boxes.

Date(s) of Service: _____ through _____				
Intake Assessment	Discharge Summary	Treatment Plan	Lab Results	Medication List
Assessments	Progress Notes (<i>limited to individual Case Management/Therapy/Dr's notes</i>)			HIV Info
Designated Record Set (includes above records plus Nurse/Group/Administrative progress notes & other items applicable for release)				
Billings Records	Other (please specify): _____			

For the purpose of:	Personal Use	Continuation of Care	Legal	Insurance
	Other, specify: _____			

This authorization applies to all applicable health information:	
<input type="checkbox"/> <u>Including</u> substance use disorder information	<input type="checkbox"/> <u>Excluding</u> substance use disorder information

Designated Recipient Information:

Name/Organization: _____				
Address: _____				
Street Address	City	State	Zip Code	
Phone Number: _____	Fax Number: _____			
Relationship to Client: _____	Email: _____			

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

<u>Paper:</u>	US Mail	Self Pickup (specify Rediscover location): _____
<u>Electronic:</u>	CD	Email to: _____ Fax to: _____

This Authorization becomes effective upon signing and will expire on _____ (<i>define date or event</i>)
If left blank, this authorization will automatically expire one year after the date signed.
Except to the extent that health information has already been disclosed or obtained, I have the right to revoke this Authorization at any time by submitting my revocation in writing to Rediscover , 1555 NE Rice Rd., Lee's Summit, MO 64086, Attn: Privacy Officer.
I may refuse to sign this Authorization, and such refusal will not affect my/the client's ability to obtain treatment unless otherwise prohibited.

Please sign and print your name below.

_____ Client/Legal Guardian Signature	_____ Date
_____ Client/Legal Guardian Printed Name	_____ 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) 966-0900 ext. 6000