Grace MindCare Record Request Form

Patient Information:

Full Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____
Address:

Street Address: _____
City: _____
State: _____
ZIP Code: _____
Record Details:

Records Requested:
[ ] Entire Medical Record
[ ] Specific Dates (From //____ To //____)
[ ] Specific Documents (e.g., psychiatric evaluations, medication records)
[ ] Other: _____

Purpose of Request:
[ ] Personal Use
[ ] Insurance
[ ] Legal
[ ] Transfer to Another Provider
[ ] Other: _____

Recipient Information (if applicable):

Recipient's Name: _____
Organization: _____
Address: _____
Phone Number: _____
Email Address: _____
Delivery Method:

Please Send Records Via:
[ ] Email (secure email required)
[ ] Fax: _____
[ ] Mail
[ ] In-Person Pickup
Authorization:

I authorize Grace MindCare to release my medical records as specified above. I understand that my records may contain sensitive information, and I consent to the release of this information to the designated recipient or for the specified purpose.

Signature: _____
Date: _____
For Office Use Only:

Request Received By: _____
Date Received: _____
Records Sent On: _____
Method of Delivery: _____