THE CENTER
for Mental Health

DATE: _____

RECORDS REQUEST

Client Name: _____ DOB: _____ Client Number: _____

Agency Requesting Records: _____

Past/Present Therapist and/or Doctor: _____

ROI Attached: ____ yes ____ no

Records Requested	Records Released
_____ Financial Information	_____ Financial Information
_____ Screening	_____ Screening
_____ Integrated Assessment	_____ Integrated Assessment
_____ Psychiatric Evaluation	_____ Psychiatric Evaluation
_____ Medical Progress Notes	_____ Medical Progress Notes
_____ Dap/Psychotherapy Notes	_____ Dap/Psychotherapy Notes
_____ Medications	_____ Medications
_____ Discharge Summary	_____ Discharge Summary
_____ Other _____	_____Other_____

Approved By: _____ Date: _____