ITERUM MENTAL HEALTH SERVICES, LLC

REQUEST FOR MEDICAL RECORDS

Address: _____ Phone: _____ Fax: _____

Date: ____ / ____ / _____

TO

Medical Records Department / Provider: _____

Address / Fax / Secure Email: _____

RE: CLIENT INFORMATION

Client Name: _____ Date of Birth: ____ / ____ / _____

Other names on record (if any): _____

To the Records Custodian:

Iterum Mental Health Services, LLC is providing mental health services to the client named above. We are requesting a copy of the client's records for the purposes of treatment planning and continuity of care. A signed authorization for release of information from the client (or the client's legal representative) is enclosed.

RECORDS REQUESTED (select all that apply)

☐ Visit / progress notes

☐ Diagnoses and problem list

☐ Medication list and history

☐ Lab results and diagnostic testing

☐ Psychological, psychiatric, or developmental evaluations

☐ Discharge or hospitalization summaries

☐ Immunization and well-visit records

☐ Referral letters and consultation reports

☐ Other: _____

Date range requested: From ____ / ____ / _____ to ____ / ____ / _____ ☐ All available records

Delivery method: ☐ Secure fax ☐ Secure email / portal ☐ Mail ☐ Pick-up

Timeframe: ☐ Routine ☐ Urgent – needed by ____ / ____ / _____

Please send the requested records to the contact below. If a fee applies for copying, or if anything further is needed to process this request, please let us know before proceeding.

Thank you for your prompt assistance.

Sincerely,

_____ Date: ____ / ____ / _____

Name, credentials / title: _____

Direct phone / fax: _____

Enclosure: Signed Authorization for Release of Protected Health Information

CONFIDENTIAL: This document contains protected health information intended only for the addressee. If received in error, please notify the sender immediately and destroy all copies.