



Medical Records Request Form Client self-request

ALL RECORD REQUESTS MUST BE ACCOMPANIED BY A COPY OF CURRENT UNEXPIRED ID

I am requesting a copy of my medical records from your office in accordance with HIPAA and California Health & Safety Code § 123100-123149.5.

CLIENT INFORMATION

Full Name:

Date of Birth:

Address:

Phone Number:

Email Address:

Medical Record Number (if applicable):

HEALTHCARE PROVIDER INFORMATION

Healthcare Provider's Name: Buckelew Programs

Address: 201 Alameda del Prado, Suite 103, Novato CA 94949

Program:

I REQUEST THE FOLLOWING RECORDS (CHECK ALL THAT APPLY):

For the date range:

To:

Treatment records

Test results

Diagnoses

Prescriptions

Consultation notes

Mental health records
(excluding psychotherapy notes)

Other (specify):

Format:

Paper copy

Electronic Copy

Delivery Method:

Mail to the address provided above

Send via encrypted email

Authorization

If you require any additional authorization forms or documents, please contact me using the information provided above.

Patient Signature:

Date:

For Office Use Only

Date Request Received:

Date Processed:

Processed By:

Email all requests to compliance@buckelew.org or send via mail to 201 Alameda Del Prado, Suite 103, Novato CA 94949 Attention: Q&C Department. All requests will be handled within 15 days from receipt.