Monarch Therapeutic Services, LLC
PO Box 8101, Manchester CT 06040-0101
Phone: 203.587.8650 **Fax**: 866.881.6464
Email: monarchpsychotherapy@gmail.com

REQUEST FOR MEDICAL RECORDS (use one form for each address records are to be sent to)

Date of Request: _____ / _____ / _____

If patient is a minor or an adult under guardianship:
Name of Legal Guardian_____ Date of Birth: ____ / ____ / ____
Relationship to Patient_____

Patient's Name: _____ Date of Birth: ____ / ____ / ____
Please Print Patient's Full Legal Name

I, _____
Please Print Patient's Full Legal Name

request _____copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I was treated in your office between _____/_____ and _____/_____.
month **year** **month** **year**

I request copies of the following health records related to my treatment:
☐ Record of Invoices and/or Co-Payments ☐ Case/Treatment Summary ☐ Progress Notes
☐ Progress Notes, Assessments, Referrals, Consultations, Treatment Plans
I understand that requested records will be provided within 30 days from date request is received, as specified under HIPAA; and that if my request cannot be honored within 30 days, I will be inform of this by letter as well as the date I might expect to receive my records.

I understand I will be charged a fee of $1.00 per page for copying the records, but will not be charged for time spent locating the records. I understand that a shipping and handling fee of $3.00 will be charged for mailing records. Expedited mailing will be charged an extra fee. I understand that if I elect to have records faxed, I will not be charged for shipping and handling.

☐ Please mail the requested records to:
Name_____

Address:_____

_____

☐ Please fax the requested records to (_____) _____ - _____.

Signature of Patient or Legal Guardian_____ Date ___ / ___ / ___