Samaritan
Behavioral Health

Samaritan Behavioral Health, Inc. (SBHI)

Request to Receive Medical Records

Date of Request: _____ Client Name: _____

DOB: _____

This is to acknowledge that I, _____

Relationship to client:

- ❑ Self
- ❑ Parent/Legal Guardian
- ❑ Other

request copies of the following SBHI medical records regarding treatment from _____(date) to_____(date) .

- ❑ Attendance
- ❑ Treatment Summary: Mental Health (MH) &/or Substance Use (SUD)
- ❑ MH / SUD Diagnostic Evaluation / Updates
- ❑ MH / SUD Treatment Progress Notes
- ❑ Occupational Therapy Eval. &/or Treatment,
- ❑ Treatment Plan – ISP
- ❑ Transfer / Discharge Summary
- ❑ Psychiatric Evaluation
- ❑ Pharmacological / Psychiatric Treatment Notes
- ❑ Pharmacy / Medication History
- ❑ Laboratory reports / results
- ❑ Crisis Evaluation / Plan
- ❑ Consultation
- ❑ Entire Record
- ❑ Other, specify below

  _____

There is a charge for copies of records unless the request is from: The Bureaus of Workers Compensation; The Industrial Commission; Ohio Department of Job and Family Services; the Attorney General; the request is for Social Security disability and accompanied with documentation that the SS claim has been filed, or other exempt institution.

_____ _____

Signature of client, legal guardian/representative Name & Relationship if not client

Identification Verification Type (Driver's license, other picture ID, etc.): _____

Date of Signature_____