SUMMIT
Community Counseling

PATIENT NAME	DOB	SSN
ADDRESS		PHONE

CLIENT REQUEST FOR PERSONAL HEALTH INFORMATION

I, or my authorized representative, hereby request that specific health information regarding my care and treatment be released by **Summit Community Counseling** to me.

Specific health information requested (check all that apply):

- ☐ All records regarding my health and treatment, including but not limited to: admission records, medical history, records requests, records received by other medical or mental health providers, facesheets, assessments, testing or evaluation reports, office notes, clinic records, consultation notes, progress notes, inpatient or outpatient treatment, clinical charts, treatment plans, other related documents, correspondence, and discharge summaries.
- ☐ All disability, Medicaid or Medicare records, including claim forms and record of denial of benefits.
- ☐ All billing records, including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period of _____ to _____.

SIGNATORY'S NAME	
PATIENT SIGNATURE (if applicable)	DATE
PARENT/GUARDIAN SIGNATURE (if applicable)	DATE
WITNESS SIGNATURE	DATE

If signed by an Authorized Representative, please describe authority to serve:

_____

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