MEDICAL RECORDS REQUEST

Client Name ___________________________________
Client Address ____
Client Phone Number ____

Today's date __________________
Name of Therapist, Service Coordinator, or Prescriber ___________________________________
Provider Address_4835 Poplar Level Rd #110 Louisville, KY 40213

To Kentucky Counseling Center, LLC:

I am writing to request copies of my medical records. Please include all records within my file.

I understand that if I choose to have records mailed to me, I will be charged postage fees.

I would like to receive my records by the following method:

____Mail (Mail records to this address____.)
____Email (My email address is __________________________________.)
____Fax (My fax number is____________________________.)

Sincerely,

Client or Guardian Signature __________________________________
Client or Guardian Printed Name ______________________________

NOTE: Under HIPAA guidelines you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.