# MENTAL HEALTH RECORD REQUEST

CLIENT LIFES HOPE THERAPEUTIC SERVICES PLLC: ______________________

DATE OF REQUEST: ______________________

DATE OF RECORD RELEASE: ______________________

THERAPIST: ______________________

You are requesting a copy of your mental health record for mental health services. The following information may be contained in your record, please indicate what part of your record you would like to receive:

______ My Entire Record

______ Part of My Record (check all that apply)

______ Life's Hope Therapeutic Services PLLC of Treating Therapist

______ Client Identifying Information

______ Reasons for receiving psychotherapy services at LIFES HOPE THERAPEUTIC SERVICES PLLC

______ Dates of services, including each date you received services

______ Mandatory Disclosure Statement

______Types of Service

______Billing/ Fee records

______Any Release(s) of Information you signed

______A summary of the assessment (if any), diagnosis (if any), and therapy treatment administered

______ Life's Hope Therapeutic Services PLLCs of test(s) that were administered (if any), dates of those dates, and the person who administered the test(s)

______ A closing statement from treating therapist

** This includes copies of any information transmitted/received electronically


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A summary of the assessment, diagnosis, and/or therapy/treatment ("Treatment Summary") may only be provided, rather than your entire client file, which may include notes that your therapist has made about your conversations during a private, group, joint, or family counseling session. Session notes may not be included if access to them may or could cause harm to you in the sole discretion and judgment of LIFES HOPE THERAPEUTIC SERVICES PLLC and its therapists.

Once the mental health record is released, LIFES HOPE THERAPEUTIC SERVICES PLLC cannot guarantee the confidentiality of the information you choose to disclose.

____ Please initial here if you would like to receive a treatment summary in lieu of your entire client record.

Once the mental health record is released, LIFES HOPE THERAPEUTIC SERVICES PLLC cannot guarantee the confidentiality of the information **you choose** to disclose.

By signing this Mental Health Record Request, you affirm that the record you are requesting is **YOUR** mental health record and reflects the mental health services **YOU** received from LIFES HOPE THERAPEUTIC SERVICES PLLC. You also affirm that a reasonable fee may be charged for copies of your mental health record.

________________________________________ ________________________

Signature Date

________________________________________

Print Life's Hope Therapeutic Services PLLC

I, (therapist releasing information), affirm that CLIENT received mental health services from me at LIFES HOPE THERAPEUTIC SERVICES PLLC and that the person requesting the information is __________.

________________________________________ ________________________

Signature Date

________________________________________

Print Life's Hope Therapeutic Services PLLC

[SPACE FOR COPY OF PHOTO IDENTIFICATION]


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