VALLEY | CITIES
Behavioral Health Care

REQUEST TO OBTAIN SELF MEDICAL RECORDS

****Records requests can take up to 15 business days for processing****

Return To: ***MEDICAL RECORDS*** | **Address:** 33405 8TH Ave S, Suite 200 Federal Way, WA 98003 | **Phone:** 206-408-5227 | **Fax** (253) 253-835-9976

CLIENT'S FULL LEGAL NAME: _____

CLIENT'S DATE OF BIRTH: _____

CONTACT PHONE NUMBER: _____

I HEREBY REQUEST A COPY OF MY MEDICAL RECORDS FROM VALLEY CITIES COUNSELING AND CONSULTATION.

☐ **All Mental Health (MH) Records**
☐ **All MH Billing/Financial Records**
Specific Dates of Service:
From _____ **To** _____
Most **recent 1 year (default if no dates listed)**

☐ **All Substance Use Disorder (SUD) Records**
☐ **All SUD Billing/Financial Records**
Specific Dates of Service:
From _____ **To** _____ **OR**
Most recent 1 year **(default if no dates listed)**

If ***ALL RECORDS*** are ***NOT*** needed, ***ONLY*** check items below:

Assessment(s)/Update(s): ☐MH ☐SUD	Active Problem List (Diagnosis): ☐MH ☐SUD	Active Medication List: ☐MH ☐SUD	Lab/UA Results: ☐MH ☐SUD
Treatment Plan(s): ☐MH ☐SUD	Group Treatment: ☐MH ☐SUD	Individual Treatment: ☐MH ☐SUD	Psychiatric Evaluation: ☐MH ☐SUD
Scheduling/Appointment History: ☐MH ☐SUD	Family Treatment: ☐MH ☐SUD	Information Related to Peer Services: ☐MH ☐SUD	Psychiatric or Medical Notes: ☐MH ☐SUD
Case Management / Community Support: ☐MH ☐SUD	Discharge Summary(s): ☐MH ☐SUD	Crisis Plan: ☐MH ☐SUD	Status Reports for Court/Probation: ☐SUD
Verification Letter for Court: ☐MH	Wraparound Records: ☐MH	Completed DOL Online Form: ☐SUD	Certificate of Completion: ☐SUD
Employment Services Records: ☐MH	Housing Records: ☐MH	MAT Notes: ☐SUD	Other: ☐MH ☐SUD

Other (specify):

I would like to receive these documents in the following manner:

☐ Electronic PDF **(Flash drive for records over 200+ no fee)** ☐ Printed on Paper **(First 30 pgs. at no cost 31+pgs .30 cents a page)**

☐ ***I consent to receiving my medical records electronically encrypted to my email address:*** _____

IMPORTANT! Encrypted emails allow Valley Cities Medical Records Department to exchange information efficiently for the benefit of our clients. We recognize that during transmission, you may be unable to open encrypted emails. Should this happen, please contact the Medical Records Department.

☐ **Please mail the records to this address:** _____
(street address) (city) (state) (zip code)

☐ **I will pick up records at the following clinic when they are ready:** _____
(clinic location)

☐ **I have a client portal account and would like the PDF version to be attached so I can download it.**

SIGNATURE REQUIRED ON PAGE 2

Valley Cities ID# _____

VALLEY | CITIES
Behavioral Health Care

I understand that:

- Only the person who has consented for care (including minors 13 years of age and older) can authorize for release of records. (RCW 70.02.130 and RCW 71.34.530). Any person who is a legal representative or durable power of attorney for the client must provide legal documentation (RCW 11.125.050).
- This authorization is my consent that allows Valley Cities to disclose information about my healthcare, mental health, substance use treatment, HIV/AIDS, and sexually transmitted diseases. These records are protected by state and federal law (RCW 70.02, RCW 70.24, 42 CFR Part 2, 45 CFR Parts 160 & 164) and cannot be shared without my written consent, except as permitted by law.
- I may cancel this authorization at any time, except to the extent that action has already been taken. To revoke authorization to release Mental Health information, I must do so in writing. I can revoke a release of Substance Use information verbally to my clinician or the program manager. Unless I cancel earlier, this release will expire once I have received the records listed above.
- I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- Once the above information is released to me, the security of the documents/information is solely within my power to control.

Signature:

Client/ Legal Authority Signature: _____ **Date:** _____

Written Name of Client/Legal Authority: _____

If the authorization is signed by a Legal Authority of the individual, a description of such representative's authority to act for the individual must also be provided.

Description of Legal Authority: _____

Relationship to Client: _____

SIGNATURE REQUIRED ABOVE

******IMPORTANT INFORMATION******

If you need updated records at a later date, a new request (this form) will need to be submitted.

Questions? Call the Medical Records Department @ 206-408-5227 (Monday – Friday from 8am-5pm)