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# _____

**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)

# Instructions on Completing a Request to Obtain Self-Medical Records

## Client Authorization to obtain my own Protected Health Information

**Section #1 (Client Information):** The legal name at time of information being requested, full address, birthdate, and phone number of the client.

**Section #2 (I hereby request a copy of my medical records)**

- Select Mental Health records/ Mental Health Billing-Financial records with specific dates of service.
- Select Substance use disorder records/ Substance use disorder Billing-Financial records with specific dates of service.
- If **ONLY** Financial/ Billing records are needed. Then only fill out that section.
- If **ALL RECORDS are** needed to be processed *check off All Mental Health records* OR *ALL Substance use disorder records*. IF both Mental Health Records and Substance use disorder records are needed then select **BOTH boxes**.
- **Specific Dates of Service**: From to End- The date of what records need to be requested/ disclosed, if no dates are mentioned then only 1 year from consent date records will be requested or disclosed.
- If you **do not want to send ALL RECORDS**, then only check the items listed for the specific record type boxes.

**Section #3 (I would like to receive these documents in the following matter):**

- Electronic flash drive (No fee *for records over 200+*)
- Printed on paper (*No fee for the first 30 pages. 31+ pages are .30 cents/page*)
- Email *if* selected, the client understands and accepts the potential of email transmission that could not be opened, which could potentially delay in getting your request in a timely manner.
- Mail records to a home address (**not an organization that requires a Release of Information**)
- Pick up records at any of the following locations: Client can select any clinic to have records sent to for pick up.
- Client portal if client has telehealth appointments and signs forms electronically. This portal can have medical records loaded in pdf format.

All requests are processed in the order they are received and legally could take up to 15 business days. Any urgency should be communicated to the medical records department as soon as possible. Once this form has been processed, anytime a new request is needed please re-submit the form each time.

**Section #5 Signatures**:

- A client aged 13 or older must sign this form unless authority has been legally assigned or designated to another individual.
- For clients younger than 13, the parent or legal guardian must sign on behalf of the client.
- For deceased clients, this form may be signed by the client's surviving spouse or personal representative (for example, administrator or executor of the estate).
- All individuals signing for, sending, or requesting healthcare information on behalf of a client must state their relationship to the client. Individuals will be required to provide proof of legal authority to permit the use of sending or requesting healthcare information.

If you have any questions or concerns, please contact the Medical Records Department at 206-408-522