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 BEHAVIORAL HEALTH CARE.

☐ **All Mental Health (MH) Records**
☐ **All MH Billing/Financial Records**
Specific Dates of Service:
From _____ **To** _____ **OR**
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:

Active Medication List: ☐MH ☐SUD	Crisis Plan: ☐MH ☐SUD	Individual Treatment: ☐MH ☐SUD	Psychiatric or Medical Notes: ☐MH ☐SUD
Active Problem List (Diagnosis): ☐MH ☐SUD	Discharge Summary(s): ☐MH ☐SUD	Information Related to Peer Services: ☐MH ☐SUD	Scheduling/Appointment History: ☐MH ☐SUD
Assessment(s)/Update(s): ☐MH ☐SUD	Employment Services Records: ☐MH	Lab/UA Results: ☐MH ☐SUD	Status Reports for Court/Probation: ☐SUD
Case Management / Community Support: ☐MH ☐SUD	Family Treatment: ☐MH ☐SUD	MAT Notes: ☐SUD	Treatment Plan(s): ☐MH ☐SUD
Certificate of Completion: ☐SUD	Group Treatment: ☐MH ☐SUD	Verification Letter for Court: ☐MH	Wraparound Records: ☐MH
Completed DOL Online Form: ☐SUD	Housing Records: ☐MH	Psychiatric Evaluation: ☐MH ☐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 at 206-408-5227 (Mon-Th: 8:30am-6:30pm; Friday: 8:30am-5pm)

Instructions on Completing a Release of Information

Client Authorization to Send or Request 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 (Request or Disclose Information): Select if you would like to Request (ask for) information, Disclose (give out) information, or Both. Then, identify the Person or Organization the request or disclosure will be sent/given to. Include the Name of person/ organization, the phone number, the email address, and the fax number. Please include the address if no fax number is available.

Section #4 (Record Types): Check boxes for which program/ record types are permitted for disclosure/request. All selections include verbal communication about the content of the selected records. Note: If this section is not completed with specific dates of services, only the previous 1 year from the date signed will be released.

- 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**.
- If **ONLY** Financial/ Billing records are needed, then only fill out that section. You may also select this box if you would like billing records included with other records.
- **Specific Dates of Service**: Start Date to End Date: The date range of what records need to be requested/ disclosed. If no dates are provided, then only the previous 1 year of records from the consent date (date the client signs the ROI) 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 of boxes.

Section #5 (Expiration- Page 2): Substance use disorder programs that fall under 42 CFR Part 2 will expire 90 days after discharge. Unless otherwise specified, all other programs release of information will automatically expire upon discharge.

Section #7 (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 206-408-5227