



Samaritan Behavioral Health, Inc. (SBHI) Request to Receive Medical Records

Date of Request: _____ Client Name: _____

DOB: _____

This is to acknowledge that I, _____

Relationship to client:

- Self
- Parent/Legal Guardian
- Other

request copies of the following SBHI medical records regarding treatment from _____(date)
to _____(date) .

- Attendance
- Treatment Summary: Mental Health (MH) &/or Substance Use (SUD)
- MH / SUD Diagnostic Evaluation / Updates
- MH / SUD Treatment Progress Notes
- Occupational Therapy Eval. &/or Treatment,
- Treatment Plan – ISP
- Transfer / Discharge Summary
- Psychiatric Evaluation
- Pharmacological / Psychiatric Treatment Notes
- Pharmacy / Medication History
- Laboratory reports / results
- Crisis Evaluation / Plan
- Consultation
- Entire Record
- Other, specify below

There is a charge for copies of records unless the request is from: The Bureaus of Workers Compensation; The Industrial Commission; Ohio Department of Job and Family Services; the Attorney General; the request is for Social Security disability and accompanied with documentation that the SS claim has been filed, or other exempt institution.

Signature of client, legal guardian/representative

Name & Relationship if not client

Identification Verification Type (Driver’s license, other picture ID, etc.): _____

Date of Signature _____