AMIGO FAMILY COUNSELING, LLC

REQUEST FOR COPY OF RECORDS TO BE RELEASED TO CLIENT

Once you have read this form thoroughly, please check the box after each paragraph and initial indicating that you have read and understand all of the information.

I (client, parent, guardian), _____, am hereby requesting a copy of the treatment record for:

_____whose Date of Birth is: _____ and whose
(Client Name)
approximate dates of service are from _____ to _____.
In requesting a copy of this record I understand that I am releasing Amigo Family Counseling, LLC (AFC) from liability for any damages, material or psychological, resulting from compliance with this request.
☐_____

I understand that some of the information in my clinical record may be sensitive and/or confusing and that there is risk that it may invoke strong emotions on my part. Therefore, if Amigo Family Counseling judges it necessary, the appropriate AFC Clinical Staff member will meet with me in person beforehand to prepare me in an interpretive chart review. I understand that I will be billed at the therapist's current AFC hourly rate.
☐_____

I understand that I can have my records released to another mental health professional in lieu of a copy being provided directly to me and I choose not to exercise that option at this time.
☐_____

I understand that portions of my record may be withheld from me if allowing my access would breach the confidentiality of someone else who has not given consent to reading the information they have provided. I understand that Amigo Family Counseling will not photocopy records which were received from other treatment providers and that if I wish to have a copy of those records, I must contact the individuals or agencies directly.
☐_____

I understand that I can add statements in writing to clarify or correct information in the treatment record.
☐_____

I understand that I will be required to present a picture identification (valid driver's license, current US Passport or valid State issued identification card) to the office staff when I pick up my copy of the record. I also understand that there will be a charge as per the current Ohio Law's established fee schedules. I will be provided a receipt and agree that payment in full is due at the time I pick up the copied records.
☐_____

The records will be available for pick up at Amigo Family Counseling, LLC , 355 East Campus View Blvd., Suite 240, Columbus, OH 43235 within 30 days of the date of this signed request during normal business hours. An AFC Administrative Assistant will notify me when the copy of the records is ready to be picked up.
☐_____

I thoroughly understand the process described above and I agree to abide by the requirements set forth by the records access policy of Amigo Family Counseling.
☐_____

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them:

☐ *Intake Summaries*	☐ *Medical History*	☐ *Mental Health Evaluations*
☐ *Progress Notes*	☐ *Treatment Plans*	☐ *Closing Summary*
☐ *Psychiatric Evaluation*	☐ *Psychiatric Progress Notes*	☐ *Psychological Testing Results*
☐ *Achievement/Other Test Results*	☐ *A Letter w/Dates Of Treatment And Progress Summary*	
☐ *Report of Teachers Observations*	☐ *Other* _____	

Signature: _____

Printed Name: _____

Address: _____

_____

Phone Number: _____

ID #: _____

Valid Driver's License/Current US Passport/Valid State Issued ID (Please note: if returning by US Mail, please include a copy of your identification)

Date of Request: _____

Witnessed By: _____

(NOTE: Signature must be witnessed by an AFC Staff Member, or, if returning by US Mail, signature must be notarized by a Notary Public)