WISDOM TRADITIONS
—COUNSELING SERVICES, LLC—

PATEINT PROTECTED HEALTH RECORDS REQUEST

I _____(patient name) consent to this request for a copy of my medical and/or behavioral health records from **Wisdom Traditions Counseling,** as is allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the Department of Health and Human Services regulations.

Address:_____Phone Number:_____

Date of Birth:_____Social Security Number:_____Email:_____

Date of Service for Records Requested:_____

I request copies of the following records:

☐Medical History provided by the patient

☐Medical provider notes, test results, consultations with specialists and referrals

☐Behavioral Health History and Assessment results

☐Behavioral Health provider notes, test results, consultations with specialists and referrals

☐Behavioral Health Treatment Plans and Discharge Summary if Applicable

☐Clinical Summary of medical records (which involves a preparation fee of $250.00.)

For each request, our staff must validate a requestor's authorization signature with a signature in the medical record; locate records; select the requested documents; review the record to ensure the authorization is valid for the release all requested information and then prepare and send the request. You may be required to show a valid form of picture identification. By signing below, you are waiving the confidentiality privilege and permitting specified information to be released to the person requesting this information. Once you have obtained a copy of your protected health information, Wisdom is no longer able to ensure your privacy, should this information be lost, stolen are otherwise disclosed. I understand that there may be a reasonable fee for copying the records, but that I will not be charged for time spent locating the records.

I request to obtain my records by:

☐Delivery by mail at the following address_____

☐Delivery through WTC Patient Portal ☐Pick up in person

☐Fax to:_____

I understand that Wisdom Traditions Counseling has 30 days to respond to my request, as specified under HIPAA. If my request cannot be honored within 30 days, please inform me of this by letter as well as state the date I might expect to receive my records.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature Witness