Send Request via email to medicalrecords@abtrs.com

MEDICAL RECORDS REQUEST FORM

Name of Client:_____**Date of Birth**: _____

I,_____, hereby authorize an exchange of information between: **A BETTER TODAY RECOVERY SERVICES…..AND**

Name_____Relationship _____

Address_____Phone # _____

Fax #:_____Email: _____

The purpose or need for such disclosure:

( ) Court
( ) Treatment Center
( ) Disability
( ) FMLA
( ) Personal Physician
( ) Other:_____

***********AT LEAST ONE BOX MUST BE CHECKED IN ALL THREE SECTIONS********

Information shall be limited to the following types of information:

1.

( ) Medical History & Physical
( ) Medical Notes
( ) Labs
( ) Certificate of Completion
( ) Discharge Summary
( ) Biopsychosocial
( ) Treatment Plan

If you have other document needs, please contact Medical Records at: 602-888-7878

And transmitted in the following fashion**:**

2. ( ) Written ( ) Verbal ( ) Audio ( ) Video ( ) Electronic

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent expires automatically as described below:

3. ( ) 6 months ( ) One year or ( ) other date _____

Executed this_____day of_____, 20____.

_____ _____ _____

Signature of client Date Signature of Witness

*Federal Register, DHEW, Confidentiality of Alcohol and Drug Patient Records (42 CFR Part 2, Subpart C, sec2.31)

** Records requests for medical or mental health continuation of care will be at no charge. Clients may receive one copy of their records for personal use at no charge (records must be requested by client and sent to client). Additional requested copies will be charged a fee: up to 200 pages -$25; 201 pages or more- $75. Fee must be received before records are released.

*** Fulfilling medical records request can take 21 business days.