BLUE SKY
COUNSELING

Medical Record Request Form

Use this form to request a copy of your records from Blue Sky Counseling.

Client Information

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

Previous Name(s), if applicable: _____

Phone Number: _____ **Email Address:** _____

Records Requested

Please indicate the records you are requesting:

☐ Complete medical/clinical record
☐ Assessment/Evaluation
☐ Treatment Plan(s)
☐ Progress Notes
☐ Medication Records
☐ Laboratory/Drug Screen Results
☐ Discharge Summary
☐ DEEP Records
☐ Substance Use Disorder Records
☐ Mental Health Records
☐ Other: _____

Date(s) of Service Requested:

From: _____ To: _____

☐ All dates of service

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How Would You Like to Receive Your Records?

☐ Pick up at Blue Sky Counseling
☐ Mail to the address below
☐ Secure electronic delivery, if available
☐ Email – I understand that regular email may have privacy and security risks
☐ Send directly to another person, provider, or organization with valid **Release of Information**

Delivery Information

Name/Organization: _____
Mailing Address: _____
City/State/ZIP: _____
Email: _____
Fax: _____

Purpose of Request
☐ Personal use
☐ Continued care/treatment
☐ Legal
☐ Insurance/benefits
☐ Other: _____

Authorization and Acknowledgment

I authorize Blue Sky Counseling to provide the records identified above to me or to the person or organization I have identified on this form.

I understand that my records may contain information related to mental health treatment, substance use disorder treatment, medications, laboratory testing, and other confidential health information.

I understand that certain substance use disorder records may be protected by federal confidentiality regulations, including **42 CFR Part 2**, in addition to other applicable federal and state privacy laws.

I understand that I may revoke this authorization in writing to the extent permitted by law, except to the extent that action has already been taken in reliance on this authorization.

I understand that requesting records does not require me to authorize disclosure of information beyond what I have identified on this form.

Email Acknowledgment, if applicable
If I request that records be sent through unencrypted or regular email, I understand that email and the internet have privacy and security risks that Blue Sky Counseling cannot control. It is possible that information sent by email could be accessed by an unauthorized third party. By selecting email delivery above and signing this form, I acknowledge and accept these risks and request that my records be sent to the email address I provided.

Client Authorization

Client Signature: _____ **Date:** _____

Parent/Guardian/Authorized Representative Signature, if applicable:

Relationship to Client: _____ **Date:** _____

If signed by an authorized representative, Blue Sky Counseling may require documentation establishing the individual's authority to act on behalf of the client.

Submit Your Request

Completed requests may be submitted to Blue Sky Counseling using the submission options listed on our website.

For questions regarding a medical record request, please contact Blue Sky Counseling.

For Office Use Only

Date Request Received: _____

Identity/Authority Verified: - [ ] Yes - [ ] N/A

Date Records Provided: _____

Method: _____

Processed By: _____