CONSENT REQUEST FOR CONFIDENTIAL HEALTH INFORMATION

Client Name: _____ DOB: _____
requests the following information:

☐	Clinical Assessment
☐	Psychiatric Evaluation / Assessment
☐	Admission / Discharge Summary
☐	Treatment Plan
☐	Diagnosis
☐	Medication List
☐	Other:

Request received via:

☐	Email
☐	Telephone
☐	Fax
☐	In person (with case manager, clinician, physician, etc.)
☐	Mail

Reason for request (optional)_____

Client Signature:_____ Date: _____