ROCKLAND
TREATMENT CENTER

Request for Medical Records

Patient Name: _____ **Patient DOB:** _____

Method of transmission:

☐Mail
☐E-mail
☐Fax

Please release information in my medical and/or financial record to: ☐ **Self** ☐ **OR:**

Contact Name or Organization: _____ Relation: _____
Phone: _____
Address: _____
City: _____ State: ____ Zip: _____
Email: _____

Reason for Release of Information: _____

Information to be released (Check all items that apply):

☐ Bio-psychosocial
☐ Psychiatric Evaluation
☐ Laboratory Reports
☐ History & Physical
☐ Treatment Plans & Reviews
☐ Discharge Summary
☐ Completion Letter
☐ Itemized Bill
☐ Other:

Attachments

In order to authenticate this request, please attach a picture of your **driver's license** or other **government-issued identification**.

Prohibition on Re-disclosure

This information has been disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. I understand that Banyan cannot ensure that information will remain encrypted if an unsecure method of transmission (such as personal email or text message) is used.

I understand that I may revoke this authorization at any time upon written notice. Such revocation will not be effective if action has been taken in reliance upon this authorization. Unless otherwise stated, this release expires in 365 days from signature.

By signing below, I attest that I am the Patient named above. Any medical records requests by a third-party on behalf of the Patient should be emailed to Medicalrecords@rocklandtreatmentcenter.com **with valid documentation authorizing the release.**

_____ _____
Patient Signature Date