EXCELSIOR

3754 W Indian Trail Rd, Spokane, WA 99208
Phone: 509-559-3100 Fax: 509-328-7582
Email: info@excelsiorwellness.org

RECORDS REQUEST

Records Requestor:			
Name: Last	First		Title(if applicable)
Organization or Business Name (if applicable)			
Mailing Address	City	State	Zip Code
Telephone Number (include area code)	Fax Number (include area code)	E-Mail Address	

Relationship to Records:
☐ Self ☐ Parent/Guardian ☐ Behavioral Health Provider ☐ Medical Provider
☐ Attorney ☐ Other:_____

(You may be asked to produce proof of identity to obtain confidential records. The client must also sign an "Authorization for the Release of Information" form indicating specifically what information may be released, to whom, and by what method.)

Client Information:		
Name: Last	First	Date of Birth
Former Names:		

Requested Documents.
NOTE: Be specific as possible so your request can be processed accurately. Please include dates (time frames) and specific documents (i.e mental health assessment, psychiatric assessment, safety crisis plan, education records, health records, discharge summary)

Requestor Signature	Date

Office Use Only:

Date Received	Compliance Officer Name	Date Records Distributed
ROIs Verified ☐ Yes ☐ No	Records Distributed	