Embodied Living
COUNSELING

Record Request

Client Name: _____ DOB: _____

Clinician: _____

Requesting Records Between the Dates From: _____ to _____.

Check which records you are requesting;

___ Assessment ___ Progress Notes ___ Treatment Plans and/or Reviews

___ Measures ___ Provider/Court Letters

___ Other: _____

Purpose of Record Request: _____

_____

_____

_____

If requesting records for your personal files, Embodied Living Counseling, LLC recommends scheduling a session with your clinician to review records in case of questions.

___ Request Appointment ___ Decline Record Review Appointment

If requesting records to be sent to someone other than yourself, please complete a release of information form (unless already completed) and submit with this request and include agency name, address, and contact person.

ROI in client chart? ___ Yes ___ No

Record requests will be completed within 15 business days of receipt of your record request and $20 processing and material fee. If your clinician or the clinical director denies your request for records, you will be notified in writing by Embodied Living Counseling, LLC with reason for denial within 30 business days.

1130 Ten Rod Rd, Suite 207C
North Kingstown, RI 02852
Phone: (401) 250 - 2731, Fax: (401) 386 - 3443
www.EmbodiedLivingLLC.org

Mail or drop off this form and payment to Embodied Living Counseling, LLC or 140 Point Judith Road, Suite 23, Narragansett, RI 02882

Client/Guardian Signature: _____ Date: _____

Name of Guardian (Printed): _____

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For Internal Use Only:

Date Request was Received: _____ Received By: _____

Date Request was Completed & Mailed (Unless given during appointment): _____
Date of Appointment if Applicable: _____

After completion of the above process/form, upload into the client's chart.