Volunteers of America®
Massachusetts

Client Request for Health Information

First Name:	Middle Initial:	Last Name:
Date of Birth (MM/DD/YYYY):	Phone:	Email (Optional):
Street Address:	City:	State: Zip Code:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ___/___/___ through ___/___/___

Information to be released:

- ☐ Alcohol & Drug Treatment History
- ☐ Contact summary/attendance/no show/and treatment progress
- ☐ Discharge Summary
- ☐ HIV/AIDS Diagnosis and/or Treatment
- ☐ Other _____
- ☐ Medical History and Physical
- ☐ Medication Information/ prescribing Information
- ☐ Mental Health Treatment History
- ☐ Social History
- ☐ Psychiatric Information
- ☐ Psychological Evaluation/Testing Information
- ☐ Psychotherapy Notes
- ☐ Urinalysis Results

How would you like your records delivered? (Check appropriate boxes below):

- ☐ Mail
- ☐ In-Person Pickup

I hereby authorize Volunteers of America of Massachusetts, Inc. to release my records to:

☐ Self (ID Required for verification) ☐ Personal Representative (indicated below)

Name of Person receiving records: _____

Please return completed form to:	

Volunteers of America of Massachusetts, Inc. recognizes a client's right under HIPAA to access copies of their health information. There may be charges associated with processing a request and producing requested records. The average cost of records is $0.50 per page 1-100 pages, and $0.25 100+ pages.

Patient Printed Name: _____ Date of Birth: _____

Patient/ Personal Representative Signature: _____Date: _____

I have received my requested records in-person on Date: _____

Patient Printed Name: _____ Date of Birth: _____

Patient/ Personal Representative Signature: _____Date:_____

The requested records were mailed on Date: _____Office Staff Signature_____