Mental Health Legacy EHR
Record Request Form

CLIENT'S INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
CASE NUMBER:	LAST FOUR OF SSN:	DATE OF BIRTH:
PREVIOUS LAST NAME:	PREVIOUS FIRST NAME:	PREVIOUS MIDDLE INITIAL

Reminder: For coordination of care purposes please leverage the SmartCare system.
All other standard requests will be processed with a goal of delivery within 15 business days.
Exceptions will be evaluated on a case-by-case basis. Please include rationale below.

PROGRAM REQUESTING INFORMATION	
NAME OF REQUESTING STAFF:	PHONE NUMBER:
STAFF EMAIL:	
UNIT Select Select Select	TREATMENT BEGIN DATE: TREATMENT END DATE:
PURPOSE OF REQUEST/COMMENTS:	

WHAT INFORMATION MAY BE SHARED

☐ **Check here to request ALL records and reports**

☐ Face Sheet ☐ Client Roster Report ☐ Progress Notes ☐ Client Plan ☐ Medications List
☐ Client Account Summary ☐ Client Services Listing Report

Assessment Forms:

☐ BHA ☐ Client Plan Confirmation Page ☐ Demographics Form ☐ Discharge Summary
☐ Initial Screening ☐ Psych Assessment ☐ State Required ☐ STRTP ☐ Other Assessment Forms

WHAT YOUR REQUEST MEANS

Sensitive Information: Records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or the Human Immunodeficiency Virus (HIV). They may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Responsibility of Program/Provider: Clinical review, redaction, appropriateness and distribution will remain the responsibility of the Program and/or Provider requesting the chart. The information requested contains Protected Health Information (PHI) and provider will use it only for the purpose stated above, in compliance with HIPAA, 42 CFR Part 2 (if applicable), and all applicable state confidentiality laws.

PLEASE SECURE E-MAIL THIS FORM TO: SDHELPDESK@OPTUM.COM