Foundation 2 Crisis Service Health Records Request

This information may be emailed, mailed or delivered in person.

Record Request Information

Personal Information

- Full Name: _____
- Date of Birth (MM/DD/YYYY): _____
- Phone Number: _____
- Email Address: _____
- Current Address: _____

Request Details

- Type of Records Requested (Please check all that apply):
  - ☐ Treatment History
  - ☐ Billing Information
  - ☐ Other (please specify): _____
- Specific Dates of Service (if known/applicable): From: _____ To: _____
- Purpose of Request (optional):

  _____

Delivery Preferences

- Preferred Delivery Method:
  - ☐ Email (encrypted for security)
  - ☐ Postal Mail
  - ☐ In-Person Pickup (Please schedule this ahead of time by contact Dmartel@foundation2.org)

- Delivery Address/Email (if different from current address):

  _____

  _____

Identity Verification

- Please attach a copy of a valid photo ID (e.g., driver's license, passport).

Authorization and Consent

I hereby request the release of my health records as specified above. I understand that my information will be handled with the utmost confidentiality and in compliance with applicable laws and regulations. I confirm that the information provided in this form is accurate and complete to the best of my knowledge.

Signature: _____

Date (MM/DD/YYYY): _____

For Office Use Only

- Received By: _____
- Date Received (MM/DD/YYYY): _____
- Verification Completed: Yes ☐ No ☐
- Comments: _____