



Mental Health Legacy EHR Interim Record Request Form



CLIENT'S INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
CASE NUMBER:	SSN:	DATE OF BIRTH:

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.

NAME OF PROGRAM REQUESTING INFORMATION

NAME OF PERSON AND PROGRAM:	PHONE NUMBER:
PROGRAM E-MAIL:	
PURPOSE OF REQUEST/ RATIONALE:	TREATMENT FROM: TREATMENT TO:

WHAT INFORMATION MAY BE SHARED

Print Clinical Forms Medications Face Sheet	Client Account Summary Client Roster
---	---

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