Daniel A. Patz, Psy.D., L.M.H.C.
Licensed Psychologist
Licensed Mental Health Counselor

Francine Odio, Psy.D., L.M.H.C.
Licensed Mental Health Counselor

CLIENT, PARENT OR GUARDIAN
REQUEST FOR RECORDS

I HERE BY REQUEST A COPY OF MY RECORD/S under the HIPPA privacy rule. I understand that only myself, or my personal representative has a right to access my records.

Date: _____

I, _____, hereby acknowledge that I have been given a copy of my records as per my request.

I, _____, hereby acknowledge that these records are protected by law and can only be provided to the individual client, parent, or guardian with proper identification. I have provided the following proof of identify:

Drivers License, Passport, or other legal document showing my identity.

Please allow up to 30 days for medical record requests to be completed. The cost of medical records is a flat fee of $6.50 for up to 30 pages or 0.11 cents per page for records over 30 pages, in accordance with Florida State law. Records are faxed free of charge to pediatricians and other specialists caring for the patient.

Please indicate how you would like to receive records when they are ready:

☐By mail ☐Picked up in person

Address: _____

Telephone number to be contacted at: _____

Email address: _____

Client Signature: _____