FAMILY COUNSELING ASSOCIATES, LLC

12 Essex Street | Andover, MA 01810
360 Route 101, Suite 12B | Bedford, NH 03110
152 Sylvan Street, Suite 12A | Danvers, MA 01923

RECORD REQUEST FORM

Patient Name: _____ **Patient DOB**: _____

I hereby request a copy of my mental health record as detailed below:

□ Full mental health record held by this office

□ Mental health record from the period_____ through_____

□ A specific portion / selection of the record described below:

_____

_____

In keeping with Family Counseling Associates **Notice of Privacy Policy Practices**, a reasonable charge is assessed for all record requests. There is a $15 flat fee to cover copying and processing costs.

Please Choose One of the Following:

□ Please fax record to: _____

□ Please send via encrypted email to: _____

□ I will pick up my record in person

□ Please mail my record to:

_____

_____

_____

Your records will be ready in 5 business days after you have submitted your request. Please attach a check payable to FCA, LLC to this request.

Signature of patient (or parent / guardian):_____

Date:_____