Acceptance & Healing LLC

RECOD REQUEST FORM

Please note that processing of record requests can take up to two weeks.

Requested by:

Client Name: _____ Date of Birth: _____
Contact Number: _____
Address _____
Street *City* *Zip Code*

Request for:
__ Detailed receipt for flex-plan (*please provide dates of service*)
__ From: _____ To: _____
__ Medical Record
__ Summary
__ Other (*please explain*):
__

Receive by:
__ Email (*superbills only*)
__ Mail
__ Pick-up
__

Comments: _____
_____
_____
_____

_____ _____
Client Name *(Please Print)* Date

_____
Client Signature

STAFF ONLY:

__ Authorization on file
__ Clinician Reviewed
__ Document signed

__ Sent on:
__ Sent by:

Comments: _____
_____
_____