Southern Minnesota BEHAVIORAL HEALTH

REQUEST FOR MEDICAL RECORDS

From Sioux Trails Mental Health Center

The following person has indicated that they have been a client of Sioux Trails Mental Health Center and has provided an Authorization to Release Protected Health Information.

Date of Request: _____

Client:

Name _____ DOB _____

Parent/Guardian Name(s) _____ Phone _____

Requesting Party:

Agency _____ Name_____ Title_____

Phone _____ Fax _____

Address _____ _____

Information Requested:

Dates: Beginning _____ and ending _____;

☐ Intake Information ☐ Progress Notes

☐ Discharge Summary ☐ Treatment Plan

☐ Diagnostic Assessment ☐ Other (Specify)_____

Please indicate how you wish to receive the records: _____ Fax _____U.S. Mail

Our standard delivery time for records is 30 days but requests for extensive or non- recent records may take longer. If you have any special requirements, please note below:

_____

Fax or mail this Request and Release to preferred clinic:

New Ulm	1407 S. State	New Ulm, MN 56073	Phone:	507-354-3181	Fax:	507-354-3199
Mankato	709 S Front St	Mankato, MN 56001	Phone	507-388-3181	Fax:	507-388-3199

For internal use only: Date received _____ By _____

Forwarded to provider: Date _____ Name _____ Office _____

Provider: Release of information on file and verified: Date _____ HIPAA tracking complete: Date _____ By _____

CSSC: Tabbed chart rec'd from provider: Date _____ HIPAA tracking complete: Date _____ By _____

Records sent: Date _____ Via: ____ Fax _____ U.S. Mail _____Other _____