

Columbus Office
431 E. Broad St.
Columbus, OH 43215
Fax: (614) 885-4058



Dayton Office
1785 Big Hill Rd
Dayton, OH 45439
Fax: (937) 264-0095

Records Request

Name: _____ Date of birth: _____ SSN: _____

Name at time of service with UMCF: (if different than above) _____

Address: _____

Preferred phone number: _____ Home Work Cell Other: _____

Records sought:

- | | |
|---|--|
| <input type="checkbox"/> Diagnostic assessment | <input type="checkbox"/> Treatment plans |
| <input type="checkbox"/> Therapy notes | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> Psychiatric progress notes | |
| <input type="checkbox"/> Other: _____ | |

NOTE: Only documents created by UMCF and its employees/contractors will be released.
UMCF will respond to your request within 30 days.

Dates of service: _____ to _____

Reason for request: Personal interest Other: _____

Name of person requesting records: _____

Relationship to client: _____ Legal Guardian: Yes No

Signature: _____ Date: _____

Identify verified by: State DL/State ID Work ID Other: _____

Authorization for release of information needed? Yes No (If no identification is attached, your signature must be notarized.)

Record number: _____ Notarized by: _____ Date: _____

Method to access requested health information: _____ Notary Public Number: _____
(Unofficial unless stamped by a Notary Public)

Please mail me a copy of the requested information to the address indicated above.

I wish to review the requested information in person.

I request that a person of my choosing be allowed to inspect my records:

Name: _____ Phone: _____ Relationship: _____

Comments: _____

Date documents ready: _____

Signature: _____ Date: _____