Trellis Counseling Client Records Request Form
HIPAA Compliant Form

Client Information:

Full Name of Client: ____

Date of Birth (DOB): ____

Phone Number: ____

Email Address: ____

Address: ____

Requestor Information:
(Complete this section if you are not the client requesting records on your own behalf.)

Full Name of Requestor: ____

Relationship to Client: ____

Phone Number: ____

Email Address: ____

Request Details:

1. **Records Requested:**
   [ ] Entire medical record

   [ ] Specific records (Please specify): ______________________________

   [ ] Billing records

   [ ] Other: ____

2. **Purpose of Request (Optional):**

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Legal Documentation:

If you are not the client, please attach appropriate legal documentation that grants you the authority to request these records (e.g., guardianship papers, power of attorney, etc.).

Legal Documentation Attached:
[ ] Yes
[ ] No (Please note, the request cannot be processed without legal documentation)

Method of Delivery:
[ ] Mail
[ ] Email (encrypted)
[ ] Pickup

Authorization:

I hereby authorize Trellis Counseling to release my protected health information as requested above. I understand that I have the right to revoke this authorization at any time by providing written notice to Trellis Counseling. I acknowledge that I have the legal right to request these records and have provided the necessary legal documentation.

Signature of Client or Legal Representative: ___________________________

Date: ________________

Printed Name: ____

Office Use Only:
Received by: ______________________________
Date of Receipt: ___________________________
Documentation Verified (Yes/No): _____________
Notes: _____________________________________

2115 SE Adams Street | Milwaukie, OR 97222-7773 | Headquarters
13110 SE Sunnyside Road, Suite B | Clackamas, OR 97015
Office: 503-659-3480 | Fax: 503-575-3707
www.TrellisCounseling.org