Mind Springs Medical Records
515 28 3/4 Road
Grand Junction, CO 81501
Phone: 970.683.7252

CLIENT/PATIENT REQUEST FOR RECORDS

** This form is to be completed by a client/patient, or a person legally authorized to act on the client/patient behalf, when they are requesting access to their own medical, clinical or business records.**

Date:_____ ID Number/Verified: _____

Client Name:_____ Date of Birth: _____

Mailing Address:_____ Zip Code: _____

Phone Number:_____ E-Mail Address: _____

I wish to access the following types of records:

____ West Springs Hospital

____ Transitions at West Springs

____ Mind Springs Health Outpatient

____ Other _____

____ Medical only *(Med Management, Diagnostic Evaluation)*

____ Clinical only *(Clinical Assessment, Therapy/DAP Notes)*

____ Billing/Financial

____ All Records From Mind Springs Health

Dates of service for requested records: From:_____ To: _____

Please give a brief explanation for this request:

_____

_____

_____

_____

When access is granted, how would you like to receive your records?

In Person_____ Mail_____ Encrypted Thumb Drive _____ Encrypted Email_____

Send them to Someone Else: _____
(You must fill out an Authorization for this option!)

I understand that in very limited circumstances I may be denied the ability to inspect or obtain my records, in whole or in part, because of a potential risk to me or to someone else, or for legally permissible reasons. Medical Records will inform me in writing of any decisions including fees that were made in regards to this records request, the reason for denial, and process of review I am entitled to.

Signature of Requester:_____ Relationship to Client: _____

Print Name: _____ Date: _____

Processing Hours for Record Requests: Mon-Fri 8:30-4:30
***Please allow up to 30 days for Medical Record processing**

CLIENT ID#_____
Internal Office Use Only