REQUEST TO INSPECT AND/OR RECEIVE COPIES OF CLINICAL RECORD
(For requests from recipient, guardian, or parent of a minor)

CLIENT INFORMATION	**REQUESTOR INFORMATION**
Name: ______________________________	**Name**: ______________________________
Birthday: ________ **Case Number**: _________	**Relationship to Client**:_____________________
Address: ____________________________	**Address**: ____________________________
City, State: ______________ **Zip**: ________	**City, State**: ______________ **Zip**: ________

I am requesting:

A Copy of Clinical Record(s): ◯ I will pick them up ◯ Please mail them to me
Review of records with an OnPoint Employee

I am requesting a copy and/or review of the following OnPoint records:

Assessments
Person Centered Plans/Treatment Plans
Progress Notes/Service Notes/Logs
Psychiatric Evaluations
Psychological Tests/Reports
Medication
Lab Results
Inpatient Hospitalization Pre-Screen
Discharge Documentation
Work-Related Information
Information Related to Benefits or Insurance
Other_____________________________

For the following time period/dates: ________________________ to ____________________________

The first 50 copied pages are provided free of charge. If more than 50 pages are requested, I understand that I will be charged 45 cents per additional page. Pre-payment may be required.

Consumer/Guardian/Parent Signature: _______________________________ **Date**:______________

Program Director Approval:_______________________________________ **Date**:______________

For Office Use Only:

Request completed on:___/___/___ by:____
Comments: