LifeStance HEALTH

Request to Access Your Record

Note: This form is to request copies of one's own records. To request to have records sent to a third party, complete an "Authorization to Share Protected Health Information"

Last Name: _____ First: _____

Other Names used: _____

DOB: ____/____/____ Phone: _____

How would you like to receive the records (check one option):

Mailed (Certified) ☐ Address: _____

_____

_____

Pick up at Clinic ☐ Clinic location: _____

Records Requested (check all that apply):

Packet (includes Assessment, Treatment plan, and Notes. No fees) ☐

Full Record set (may include additional fees) ☐

Other records wanted: ☐

Specify: _____

_____

_____

Dates of Service:

Date From: _____/_____/_____ Date to: _____/_____/_____

All dates of service: ☐

Provider(s):

Provider(s): _____

All Lifestance Providers: ☐

Patient/ Personal Representative

Signature: Date: _____/_____/_____

_____

If personal representative: Print Name: _____

Relationship to client: Parent- ☐ Guardian- ☐

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