HEART OF TEXAS
Behavioral Health Network

Administrative Offices
6400 Imperial Drive • PO Box 890
Waco, TX 76703-0890
Phone: (254) 752-3451

Form 1.8-D
Revised May 12, 2017

Request for Records

Instructions: Complete all sections. Submit the completed form to:

Email:	Fax:	Mail address:
RecordsRequests@hotbhn.org	(254) 752-7421	P.O. BOX 890 Waco, Texas 76703

1. Client Information

Full Name: _____ Date of Birth: _____
Social Security Number (SSN): _____ Phone Number: _____

2. Information to Be Disclosed

Please describe the records or information you are requesting:

_____

_____

3. Timeframe of Information to Be Disclosed

From: ____ / ____ / _____ To: ____ / ____ / _____

4. Purpose of Request

☐ Continuation of Care ☐ Legal / Insurance Purposes
☐ Personal Use ☐ Other: _____

5. Method of Delivery

☐ Pick up in person ☐ Mail to: _____
☐ Fax to: _____ ☐ Email (secure): _____

6. Fee Acknowledgement

I understand that I have the right to review and request copies of my mental health records. I understand that a reasonable fee may be charged for copies of records, as allowed by HIPAA and Texas law. If fees apply, I understand that they will be explained to me before copies are provided.

7. Authorization & Signature

I authorize **Heart of Texas Behavioral Health Network** to release the information described above. I understand this authorization is valid for one-time disclosure unless otherwise specified. I may revoke this authorization at any time in writing, but revocation will not affect information already released.

Signature of Client or Legal Representative: _____ Date: ____ / ____ / _____
Relationship to Client (if signed by legal representative): _____

Submitting this request will not affect your services or result in retaliation.
This form is provided pursuant to Texas Health & Safety Code Chapter 181 and HIPAA.