

Request for Records

Instructions: Complete all sections. Submit the completed form with a **copy of photo ID** via:

Email:	Fax:	Mail address:
RecordsRequests@hotbhn.org	(254) 752-7421	PO 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: _____

Email (secure): _____

Fax to: _____

Email (unsecure): _____

**I understand that unencrypted email is not secure and may involve privacy risks, and I authorize my records to be sent to me by unencrypted email.*

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): _____