

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): _____



NOTICE OF FEES FOR COPIES OF RECORDS

Our agency is committed to ensuring clients have access to their records while minimizing financial barriers. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), we may charge a reasonable, cost-based fee for copies of records.

Maximum Standard Fees

- **Electronic copies (email/fax):** Cost-based fee (Ex. exporting/converting/redacting)
- **Paper copies:** \$25.00 flat fee for the first 20 pages (\$0.50 per page after 20 pages)
- **Postage (if mailed):** Cost of paper copies (see above) plus postage (current USPS rate)

If any fee applies, you will be informed of the total cost before records are released.

FEE WAIVER REQUEST

If you have limited or no income and are unable to pay the copying fee, you may request a waiver below. No proof of income is required. Services will not be denied due to inability to pay.

I am requesting a fee waiver because:

- I currently have no income.
- I receive limited public assistance (SSI, SSDI, SNAP, etc.).
- Payment of this fee would create financial hardship.
- Other (please explain): _____

Optional explanation (if desired): _____

SIGNATURE

I understand that my request will be reviewed promptly and that records will not be withheld solely due to inability to pay.

Client Name (Printed): _____ Date of birth: _____

Signature: _____ Date: _____

Staff Use Only:

- Waiver Approved
 - Waiver Denied
- Staff Name: _____ Date: _____