LIFE in BALANCE
COUNSELING & WELLNESS CENTER
Enriching Mind, Body & Spirit

400 Roanoke Street
Christiansburg, VA 24073
Phone: 540-381-6215
Fax: 540-381-6216
Email: lifeinbalancecenter@gmail.com

CLIENT REQUEST FOR RECORDS

In Virginia, patients may access their own medical records but may not see mental records if a physician believes doing so would be injurious to that person's mental health. All HIV/AIDS test results are confidential as well, but available to that patient's lawyer, Department of Health, parents (if a minor), spouse, or through a court order.

Patient Name: _____ **Date of Birth:** _____

Phone Number: _____

I understand that it may take up to 15 business days to retrieve and make copies of my records. I understand that there is a **Record Printing Fee** for copies to be made and this fee is due when records are released.

Record Printing Fee Schedule		
Charges as per Virginia Code §8.01-413 Section B2		
$0.50 per page, up to 50 pages	Number of Pages: _____	Total Charge: $_____
$0.25 per page thereafter	Number of Pages: _____	Total Charge: $_____
Search and Handling Fee: $20.00	----------	Total Charge: $ 20.00
Total Due:		**$**_____

To protect personal client information, records must be picked up in person. A valid Photo ID must be presented prior to records being released.

An administrative staff member may call me at the above phone number when records are ready to be picked up. If I am unavailable, I hereby authorize **Life in Balance Counseling & Wellness Center** to leave a voicemail notifying me that my records are available for pickup.

The estimated date that record request will be ready for pickup: _____

I understand that a staff member may make up to 3 attempts to contact me and that after no response, the photocopies of my records will be shredded to protect personal information.

Patient Signature: _____ Date: _____

If patient is a minor: ☐Parent ☐ Guardian **Name:** _____

Signature: _____ **Date:** _____

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CLIENT REQUEST FOR RECORDS

FOR OFFICE USE

Date Request Received: _____ **Patient ID:** _____

Request Received By: _____

Copy and release the following: ☐ Intake Assessment ☐ Progress Note(s)

☐ Other: _____

Date Client Notified of Pickup: _____ **Notified by:** _____

Second Notice: _____ **Notified by:** _____

Final Notice: _____ **Notified by:** _____

RECORD PICKUP CONFIRMATION: REQUIRES SIGNATURE

Records were pickup up by: ☐ Patient ☐ Parent ☐ Guardian

Printed Name: _____

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____