

Record Request

| Date of Request: | |
|--|---|
| Client Name: | Client DOB: |
| Person Requesting: | Phone: |
| Agency: | Email: |
| Reason for Request:Information Requested: | |
| Psychiatric Evaluation Treatment Plan(s) Clinical Summary Assessment TCM Notes TCM Service Plan Other: Records to be provided to: | Psychiatric Progress Note Discharge Summary |
| · | cy: |
| Address: | |
| Phone number: | |
| Fax Number: | |
| Email Address: | |
| ** Records will not be released to a third party without a Information authorization, along with the legal paperwork | • |
| Release On File Release Attached | |
| Families First of Florida (FFF) will send/provide Electronic H however if the client or the client's personal representat make healthcare decisions asks FFF to send EHI to an unse held liable for third party release | ive who has been granted the authority to ecure destination/device then FFF cannot be |

Please email the completed form to records @familiesfirstfl.com or fax to (813) 354 - 2416 Attn: Records