New Leaf Behavioral Health

Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records are being requested? (complete sections and check appropriate boxes below)

Date(s) of Service: _____ / _____ / _____ through _____ / _____ / _____

☐ Treatment Records ☐ Discharge Summary ☐ Other (please specify): _____

How would you like your records?

☐ Paper Records, In-Person Pickup

☐ Electronic (please specify one):

- ☐ Email*
- ☐ Fax*

*Records sent to an email address or fax number shared by others may not be secure.

Who do you want the information sent to (or) Who will be picking up the information?

Recipient Name:	Recipient Phone / Fax:
Recipient Mailing Address:	Recipient Email Address:

Please Print Your Name and Sign Below:

_____ _____

Name of Patient, Parent or Legal Guardian* (please print) Relationship (if other than self)

_____ _____

Signature of Patient or Parent or Legal Guardian* Date

*In cases of shared custody or legal guardian status, please send over the most recent custody agreement or legal guardian status with this request.

For All Requests: Please include a copy/scan of your driver's license with this request.

Please Return Completed Form to:

New Leaf Behavioral Health
3725 National Drive, Suite 220
Raleigh, NC 27612

New Leaf Behavioral Health recognizes a patient's right under HIPAA to access copies of his or her health information. Charges may be associated with the processing and producing of requested records.