Record Request

Date of Request: _____

Client Name: _____ Client DOB: _____

Person Requesting: _____ Phone: _____

Agency: _____ Email: _____

Reason for Request: _____

Information Requested:

- ☐ Psychiatric Evaluation
- ☐ Monthly Reports
- ☐ TCM Notes
- ☐ Other: _____
- ☐ Treatment Plan(s)
- ☐ Bio-psychosocial
- ☐ TCM Service Plan
- ☐ Psychiatric Progress Note
- ☐ Medication Logs
- ☐ 5339

Records to be provided to:

Name: _____ Agency: _____

Address: _____

_____

Phone number: _____

Fax Number: _____

Email Address: _____

***** Records will not be released without a current, HIPAA compliant Release of Information authorization, along with the legal paperwork to support the authorizing signature.***

☐ On File

☐ Attached

Please fax the completed form to the appropriate Service Center (see fax numbers listed below).

Telephone Number *(813) 290-8560 (Choose Your Service Center Accordingly)*
Fax Numbers *● Lakeland (863) 583-0392 ● Marianna (850) 290-7442 ●Ocala (352)354-9166*
● Orlando (407) 386-7429 ● Pinellas Park (727) 683-9849 ● Tampa (813) 354-2416 ● Tallahassee (850) 290-7442
www.familiesfirstfl.com