Mind Springs Medical Records
515 28 3/4 Road
Grand Junction, CO 81501
Phone: (970) 683-7252

CLIENT/PATIENT REQUEST FOR RECORDS

** This form is to be completed by a client/patient, or a person legally authorized to act on the client/patient behalf, when they are requesting access to their own medical, clinical or business records.**

Date: _____ Client ID Number: _____

Client Name: _____ Date of Birth: _____

Mailing Address: _____ Zip Code: _____

Phone Number: _____ E-Mail Address: _____

I wish to access the following types of records:

_____ West Springs Hospital
_____ Transitions at West Springs
_____ Mind Springs Health Outpatient
_____ Other _____

_____ Medical Only *(Med Management, Diagnostic Eval)*
_____ Clinical Only *(Clinical Assessment, Therapy/DAP Notes)*
_____ Billing/Financial
_____ All Records

Dates of service for requested records: From: _____ To: _____

This is a standing request to receive updates on my records, good for 6 months: _____
(I understand I must notify Medical Records to receive my records)

Please give a brief explanation for this request:

_____

_____

_____

_____

When access is granted, how would you like to receive your records?

_____In Person _____Certified Mail _____Encrypted Flash Drive _____Encrypted Email

Send them to someone else: _____
(You must fill out an Authorization for this option!)

I understand that in very limited circumstances I may be denied the ability to inspect or obtain my records, in whole or in part, because of a potential risk to me or to someone else, or for legally permissible reasons. Medical Records will inform me in writing of any decisions including fees that were made in regards to this records request, the reason for the denial, and the process of review I am entitled to.

Signature of Requester: _____ Relationship to Client: _____

Print Name: _____

Processing Hours for Records Requests: Mon—Fri 8:30—4:30
Please allow up to 30 days for Medical Record processing