Ascension Eastwood
Behavioral Health

REQUEST LETTER FOR PROTECTED HEALTH INFORMATION

NAME OF CLIENT/PATIENT: _____

DATE OF BIRTH: _____ SS#: _____

DATE(S) OF TREATMENT AT EASTWOOD: _____

NAME OF REQUESTOR: _____

RELATIONSHIP TO CLIENT/PATIENT: _____

PHONE #: _____ ALT. PHONE #: _____

ADDRESS: _____ CITY _____ ZIP _____

SPECIFIC INFORMATION BEING REQUESTED: _____

_____

_____

_____

REASON INFORMATION IS BEING REQUESTED / HOW WILL IT BE USED: _____

_____

_____

_____

SIGNATURE: _____ DATE: _____

RETURN COMPLETED LETTER TO ASCENSION EASTWOOD BEHAVIORAL HEALTH:

FOR INTERNAL OFFICE USE ONLY:

____Authorization to Release PHI Needed

____Additional Authorizing Signatures Needed

____Clinical Mgr Waived Interpretation Session

____Custody Papers Needed

____Release Directly to Other Professional

____Released to Requestor on: _____