18 Park Ave
PO Box 923
Mt. Airy, MD 21771
410-346-0097
rootstowingstherapy.com

Medical Records Request Form

IMPORTANT: *Medical records must be requested in writing. Federal HIPAA law permits release of mental health records under certain conditions. Requests must be authorized by the patient, parent(s) guardian(s), or authorized representative. If the client is aged 18 or older, is aged 16 and signed their own consent for treatment, or is an emancipated youth, the client is the only person who can release medical records. Releases of records can be revoked by the patient in writing at any time. Per Maryland and Federal law, Roots to Wings, LLC reserves discretion when releasing records of clients due to the sensitive nature of mental health records. Roots to Wings may fully or partially withhold records if: (1) it relates to a psychological issue; and/or (2) it could cause harm to the patient. In some cases, Roots to Wings may provide a summary in lieu of full session notes or assessments. Another medical professional treating the individual for the same reasons as RTW may also review the records and determine whether they may be released or not. RTW will not release records to a parent who does not have legal custody of the child. RTW must comply with subpoenas for records requests signed by a judge and any criminal or abuse investigations, including providing records requested by law enforcement.*

Per our policy, in cases where parents are divorced, separated, or are ordered to share custody of minor children, Roots to Wings will provide any records requested to both/all legal guardians, not simply the one parent who requested the documents. The other parent will be notified that a records request has been made by the other parent.

Health care providers may not refuse to disclose a medical record on the request of a person in interest because of the failure of the person in interest to pay for health care rendered by the provider. Roots to Wings is allowed up to 21 days to release records from the date the request is received, per Maryland law.

Please note that certain records are offered special protection under law, including records pertaining to substance abuse treatment, HIV/STDs, and termination of pregnancy.

Under Health-General Article, §4-304, Annotated Code of Maryland, health care providers are permitted to charge patients (or the patient's authorized representative) a fee for providing records.

Roots to Wings Fees for Records Release:

-To the Patient or Patient Representative:
  Electronic: 57 cents per page, up to $80
  Paper: 76 cents per page, up to $80 + postage & handling

-To a 3rd Party:
  Electronic: 57 cents per page, up to $80 + $22.88 prep fee

Paper: 76 cents per page, up to $80 + postage & handling + $22.88 prep fee

Please complete the following:

Client Name: _____ DOB: _____

Name of person requesting records: _____
Agency or Organization requesting records: _____
Phone Number: _____
Address: _____
Email: _____

Preferred mode of communication:

- ☐ Mail (provide address if different from above)
- ☐ Secure electronic transmission (provide email address if different from above)
- ☐ Pick up from the office (18 Park Ave, Mt. Airy, MD 21771)

  ***We do not have access to a fax machine*

Please provide specific information regarding the documents you are requesting. Also indicate if a summary of services will be sufficient in lieu of session notes or other sensitive material:

_____

_____

I understand that I will be provided with an invoice for the cost of providing medical records as indicated above and allowable under Federal and Maryland law. I understand that while Roots to Wings will take every precaution to ensure that the records are provided in a secure manner (snail mail with tracking number or secure, password protected email), it is my responsibility to ensure that the records will remain secure and confidential after delivery. I also understand that my request may be denied or may be modified if the request is found to be part of an exemption provided under law, as indicated above.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____ Date:_____