

Please ensure all fields are complete, legible, and **sign** and **date** the form. Failure to properly complete each field may result in a delay in sending out the requested records. Requests are completed in the order of receipt and can take up to 30 days for completion unless notification of an extension is received. Any request may be granted or denied. It is understood that if this request is denied, a request for a review of the denial is permitted if requested.

**Client and Requestor Information** Print the client's full/legal name and any other names that records may be under while client was in treatment (e.g., client's maiden name). If you are requesting records that are not your own, please also include your name, organization (if applicable), and contact information.

**NOTE:** Be sure to include the method for which you want the information to be delivered. (i.e., physical address for mail, fax number for fax or email address for email.)

**Requested Information and Timeframe/Dates of service:** Please indicate specifically what records are needed and provide a date range for the records being requested. (ex. 1/1/2024-3/2/2024)

**Return the completed, signed form as follows:**

Email: [medicalrecords@rosecrance.org](mailto:medicalrecords@rosecrance.org)

Fax: (815)-720-5089

Mail: (below address)

**Illinois:**

Rosecrance Behavioral Health  
Attn: Medical Records Department  
1021 N. Mulford Road  
Rockford, IL 61107

**Iowa:**

Rosecrance Jackson Centers  
Attn: Medical Records Department  
800 5th Street  
Sioux City, IA 51101

**Fees:** There may be a processing fee. Fees depend on the number of pages copied and are assessed in accordance with state and federal regulations. For more information on fees please visit our website at [www.rosecrance.org](http://www.rosecrance.org).

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*By signing this document, I authorize the third party listed below to access my medical records using the delivery method(s) I have selected.*

Requestor Name (if different from client): \_\_\_\_\_

Address: \_\_\_\_\_

Associated Company/Organization: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**How would you like to receive your request?** ☐ Email ☐ Mail ☐ Fax ☐ Pick Up (in-person)**Purpose of Disclosure?** ☐ Client Request ☐ Legal ☐ Continuing Care ☐ Insurance☐ Other (please note): \_\_\_\_\_**Dates of information requested (service dates):** \_\_\_\_\_ to \_\_\_\_\_  
Start End**Check All Information to be disclosed:** ☐ All Listed

- |   |   |
|---|---|
| <input type="checkbox"/> Assessment Summary and Recommendations/IMCANS        | <input type="checkbox"/> Discharge Summaries    |
| <input type="checkbox"/> Medical Information (ex. physical exam, medications) | <input type="checkbox"/> Toxicology/Lab Reports |
| <input type="checkbox"/> Psych. Evaluation(s)/Notes                           | <input type="checkbox"/> Diagnosis Information  |
| <input type="checkbox"/> Treatment Plan(s)                                    | <input type="checkbox"/> Progress Notes         |
| <input type="checkbox"/> Other (please specify): _____                        |   |

**Client Agreement:**

I understand that the confidentiality of behavioral health patient records are protected by HIPAA, 42 CFR Part 2, and all applicable state confidentiality laws. I understand that if I refuse to sign this authorization, no information will be released, and I will not be denied treatment. Rosecrance has the right to disclose information as permitted by this authorization in any manner that is deemed appropriate and consistent with applicable law, this includes verbal, paper, and electronic submissions. I understand that I have the right to revoke this authorization at any time. This authorization will expire in one year from the date signed unless I request an earlier expiration.

\_\_\_\_\_  
Client Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Parent, guardian, or personal representative Signature\_\_\_\_\_  
Date

*(in Illinois: Clients aged 12-17 years old are requested to sign and date with co-signature of parent/legal guardian)*