To request medical records, please follow the steps below:

1. **Download the Medical Records Request Form**
   Ensure that you fill out the form completely.
2. **Complete the Form**
   Make sure to provide all necessary details in the form. Incomplete forms may cause delays in processing your request.
3. **Sign the Form**
   Your request will not be processed without a signature. Please ensure the form is signed before submitting.
4. **Email the Form**
   Once completed and signed, email the form and a copy of your driver's license to: **records@serenityhealthgrp.com**.
5. **Processing Time**
   Please allow up to 30 days for us to process your request and provide the medical records. We will notify you once the records are ready for release.

If you have any questions or need assistance, feel free to contact us at **records@serenityhealthgrp.com**.

Authorization For Use/Disclosure of Protected Health Information

Medical Record Request Form

PATIENT INFORMATION: The following information is needed to assist the organization in locating the patient's medical record.	
Patients First and Last Name:	**Patients Date of Birth:**
Patients Street Address:	**Patients Phone Number:**

If requesting on behalf of the patient:	
First and Last Name of person/Facility Name:	**Phone Number:**
Relationship to Patient:	

REQUEST Authorization: I hereby authorize the listed facility below to disclose records:

- Red Top Wellness Center- Cartersville GA

DISCLOSURE: Records to be disclosed to the person or entity listed below by:

- **Secure E-mail**
- **Fax**

Name of person or entity:
Street Address:
City/State/Zip:
Phone Number:
Fax Number:
Purpose of Request: personal records legal records continuity of care Other

DESCRIPTION OF INFORMATION FOR RELEASE:

- **Entire Medical Record**
- **Abstract of the Record***
- **Financial Record**
- **Biopsychosocial Assessments**
- **Psychiatric History and Assessment**
- **History & Physical**
- **Medical Progress Note**
- **Medication List**
- **Laboratory Test Result**
- **Discharge summary**

****An abstract of the record includes the History/Physical Assessment, Biopsychosocial assessment, Treatment Plans, Discharge Summary****

AUTHORIZATION FOR USE/DISCLOSEURE OF PREOTECTED HEALTH INFOMATION

I understand that the information that I am authorizing to use/disclose may include information related to the diagnosis or treatment of mental illness, substance abuse, chemical dependency, and alcohol abuse, including privileged psychiatric or psychological communications and other detailed mental health information; infectious diseases, such as HIV/AIDS, tuberculosis or hepatitis. I hereby waive any privilege concerning such information for the disclosure to the person or entity I have authorized above. **I understand that the information used/disclosed pursuant to this authorization will not include psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing contents of conversation during a counseling session that are kept separate from the rest of the medical record.**

I understand that unless otherwise limited by state or federal regulations, I may revoke this authorization at any time by presenting my revocation in writing to records@serenityhealthgrp.com

I understand that this authorization is specific to the information, purpose and date(s) of services indicated above. I understand further that this authorization is valid for 90 days from today's date and will expire at that time.

Note: There may be fees for provision of the information requested; however, records for treatment purposes may be faxed to the patient's healthcare provider when requested at no charge. Under most circumstances, applicable law permits up to thirty (30) days for record requests to be processed.

Patient or Legal Representative Signature: _____

Please Print name: _____

Today's Date: _____

Time: _____

As a Legal Representative, my relationship to the patient is _____.
Any document proving such authority must be attached.

The patient is unable to sign because:
_____