DIVERSUS HEALTH

# Request for Medical Records from Diversus Health

**This is NOT an authorization to release records, an authorization/release is still needed**

**Date of Request:** _____ **Date Needed by:** _____

## CLIENT & REQUESTER INFORMATION

**Client Name:** _____

**Client DOB:** _____ **Client ID:** _____

## FACILITY / DOCTOR

**Requestor/Agency:** _____

**Address:** _____

**City, State, Zip:** _____

**Phone:** _____ **Fax:** _____

**Email:** _____

## INFORMATION BEING REQUESTED

**Date Range of Records Requested:** _____ **TO** _____

- ☐ Initial Diagnostic Assessment (Intake)
- ☐ Psychiatric Assessments/Evaluations
- ☐ Medications Prescribed
- ☐ Diagnosis
- ☐ Psychological Assessment (Special approval is required from Client, Legal Guardian or Client Representative)
- ☐ Treatment Plan(s)
- ☐ Medical Progress Note(s)
- ☐ Labs Results
- ☐ Other: _____
- ☐ Therapy Progress Note(s)
- ☐ Discharge Summary
- ☐ Genetic Testing Results

## PURPOSE OF REQUEST

- ☐ Care Coordination
- ☐ At the request of the individual
- ☐ To determine eligibility for services
- ☐ Other

## SUBMIT REQUEST TO ONE OF THE FOLLOWING

**Mail:** Diversus Health Medical Records, PO Box 15318, Colorado Springs, CO 80935

**Fax:** 719-314-4257

**Email:** MedicalRecords@DiversusHealth.org

**Questions:** 719-314-4283

Signature of requester: _____ Diversus Health staff: _____