The Gronowski Center
5150 El Camino Real, Building C-15
Los Altos, CA 94022
Tel. (650) 961-9300 Fax: (650) 961-9310

Request for Records

Client Name: _____ DOB: _____

I request that a copy of my records be submitted to:

_____ _____
Name of Person or Agency (include Title/Position if applicable) **Relationship of Person to Client**

_____

_____
Address and Phone Number of Person or Agency

I request that my records be limited to the following specific information:

1. _____ All records
2. _____ Summary of psychosocial and psychiatric history
3. _____ Diagnosis only
4. _____ Medical information including results of medical tests
5. _____ Results of psychological assessment
6. _____ Educational assessment and behavior reports
7. _____ Legal status only
8. _____ Other:_____

Purpose of records request:

____ Personal ____ Legal ____ Medical ____ Disability

____Other: _____

I understand that upon approval from the Clinic Director for the release of records, I will be charged $0.35 per page copied. I also understand that in the case of an unusually high volume of records, it may take up to 30 days for the request to be fully processed.

_____ _____
(Signature of Client) (Date of Signature)