LEARN Behavioral

Client Record Request Form

Please send the completed request form and any inquiries via email to **Record.Request@learnbehavioral.com** or fax to **(424) 209-1660.**

*Please use the information below to determine which client records you would like to request.**

Record Type	Description
Assessment Report	Initial assessment conducted by licensed clinical staff, which details client's behaviors and proposed treatment.
Authorizations	Approvals of authorized services made by the client's funding source. Typically sent to the client's family at the time of receipt (dependent on funding source requirements).
Formal Correspondences	Formal communications sent to parents, incident reports, previously fulfilled record requests, etc. Does not include email correspondences, unless specifically requested.
Psychological Evaluations	Initial psychological evaluations conducted with LEARN, by a licensed clinical psychologist.
Referral Packet	External documents collected prior to client's services with LEARN (i.e. psychological evaluations, doctor's recommendations, insurance information, etc.).
Session Notes	Notes and observations made by providers at the end of each session.
Treatment Plans	Periodic reports containing program goals, progress toward targets, resulting data, and service recommendations.

**Requested records will only be sent if available in the client's record.*

This request form should be used by all affiliates of the LEARN Behavioral Provider Network, including: AST, BACA, BCI, Priorities, SPARKS, Tandem Therapy, Total Spectrum, Trellis, UP Autism, and WEAP.

Your request for client records will be processed and fulfilled within fifteen (15) business days. Please note that additional processing time may be necessary if records are retrieved from an off-site facility. Records will be provided via the delivery method specified below. Once all records are retrieved, we will notify you of any charges via phone call and provide you with an invoice. **Please be sure to sign the form. Unsigned requests cannot be processed. Must be signed by a legal guardian or representative.**

Client's Name (Print) | **Date of Birth**

Name of Person Requesting Records

Relationship to Client | **Contact Phone Number**

Your LEARN Provider: ❑ AST ❑ BACA ❑ BCI ❑ Priorities ❑ SPARKS ❑ Tandem Therapy ❑ Total Spectrum ❑ Trellis ❑ UP Autism ❑ WEAP ❑ Other (Please specify):

Please include copies of (Check all that apply):

- ❑ Assessment Report
- ❑ Psychological Evaluations
- ❑ Authorizations
- ❑ Treatment Plans
- ❑ Referral Packet
- ❑ Formal Correspondences
- ❑ Session Notes
- ❑ Other (Please specify):

Dates of Record(s)

Delivery Method *Note: The Company's default delivery method is a HIPAA-compliant, fully-encrypted and password protected email sent to the email address on file or indicated on this form. If paper records are requested by mail, the Company will charge a per-page fee of 10 cents + US Postage. Additional charges may apply for videotape requests.*

❑ Check if request by Fax/e-Fax (No charge)
❑ Check if request by Mail (You consent to the fee charges above)

Send records to (fill out applicable information below):

Name | Email

Phone | Fax

Address

City | State | Zip Code

Comments

I understand that I have the legal right, within certain limitations to either view or obtain copies of treatment plans and related records of my child. I understand that the raw data is clinically analyzed by the staff and should not be misinterpreted. I will direct any questions about the data, reports, and other items to our Program Supervisor.

Signature: | **Date:**