Records Request

I, ______________________
(Please print full name)
request a copy of my _____________
(i.e.: Assessment, Release Summary or complete record) from my Region Ten CSB medical record.

My date of birth is _________.

I would like my records

☐ Mailed

☐ Emailed to: ________________

☐ Faxed to: __________________

☐ I will pick up at 500 Old Lynchburg Rd.

Signature: _______________________
Date: ______________
Phone Number: ___________________
Address: _________________________
____

*Please note, it can take up to 14 business days to prepare and send out these records. *