REQUEST FOR HEALTH INFORMATION

Instructions: This form is to be completed by non-Health Services staff to request health information from DOC Health Services.

NAME (Last, First): ____________________________ DOC NUMBER: ________ DATE: ________

Reason for requesting patient health information

Choose one

Type of information being requested

☐ Medications  ☐ Medication compliance  ☐ Ongoing health issues
☐ Physical limitations  ☐ Work restrictions and duration  ☐ Physical disability/mental impairment
☐ Accommodations required  ☐ Mental Health Appraisal  ☐ Behavioral Health Discharge Summary
☐ Mental health diagnoses  ☐ Typed mental health notes  ☐ Mental health treatment records (all)
☐ Psychological evaluation  ☐ Other:

Date information needed by

Click here to enter a date.

REQUESTING STAFF NAME (FIRST AND LAST): ____________________________ TITLE: ____________________________ FACILITY/UNIT, FIELD OFFICE or HQ UNIT: ____________________________

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.