Pasadena Clinical Group, APC
Request of Medical Records
Tel: 626 - 354.6440
Fax: 323-801-8264

PO BOX 5512
Pasadena, CA
91117

Instructions:

- Complete this form entirely. If any area is left unanswered or blank, or any part of the information is incorrect, the form becomes legally invalid per federal law. Each time you request a document from us a new authorization must be filled out; this is done to ensure HIPAA compliance so that your request can be processed without delay. (Your initials_____)

- There is a cost of $0.25 per page (California Health & Safety Code §123110); a down payment of $15 or $20 (depending on the documents requested) will be charged at the time your request is processed. Any balance will be charged to your credit card automatically; any credit will be refunded directly to the credit card used, no exceptions. (Your initials_____)

- We accept only credit cards: once you have submitted all the information, your credit card will be processed within 2 to 3 business days (excluding week-end and holidays), then your request to access your medical records will be processed. (Your initials_____)

- Once your records are ready for pick up we contact you and schedule an appointment to pick up your documents. Courtesy services, such as faxing, emailing or postal mailing, are available for a flat fee. You can verify the cost associated to any of these services at this link: https://mhccla.com/forms/courtesy-services/ (Your initials_____)

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PATIENT'S INFORMATION

Is the patient a minor? _____ Patient's Full name: _____
DOB: _____ Age:_____ Address: _____ City: _____
State:_____ Zip Code: _____ Phone Number: _____
Mailing address (if different from above) _____
Email address: _____
Type of identification _____ Number:_____ Issuing State/Country: _____
Has the patient been declared incapacitated by a judge/court of law? _____
If yes, please attach all court's documents in one single PDF file (Max size 10MB) _____

REQUESTING PARTY (IF APPROPRIATE)

Requesting party: _____ Other: _____
First name: _____ Middle Initial: ____ Last name: _____
Date of birth: _____ Age: _____ Address: _____
City: _____ State: _____ Zip code: _____ Ph#: _____
Type of identification: _____ Number:_____ Issuing State/Country: _____

PAYMENT INFORMATION

Document(s) you are requesting:

☐ Results of psychological tests ☐ Informed Consent ☐ Psychotherapy notes ☐ Privacy Policy
☐ Arbitration agreement ☐ HIPAA regulations ☐ Other:

_____

Delivery: ☐ USPS (no charge) ☐ Fax (no charge) ☐ Email (no charge)
☐ Other (ex. Overnight DHL delivery): _____

If you selected Other, please complete the part below:

Credit card # _____ Expiration date: _____ CVV: _____
Name on card: _____ Billing Zipcode: _____ Card type: _____

_____

NAME OF PATIENT SIGNATURE DATE

Please attach a copy of a government-issued ID (ex., Driver's license).

_____

NAME OF GUARDIAN/REQUESTING PARTY (if appropriate) SIGNATURE DATE

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Please attach a copy of the requesting party's driver's license.

Please mail all the documents to:

Pasadena Clinical Group
Att. Medical Record
PO BOX 5512
Pasadena, CA, 91101

It is advisable to use a tracking system, like USPS-certified mail. All costs are the patient's responsibility. Feel free to provide us with your tracking number so that we provide you with an update once received.

Should you have any questions or require further assistance, please do not hesitate to contact us at 626-354-6440 or by email at accounts@pasadenaclinicalgroup.com

Sincerely,
Pasadena Clinical Group