CA PSYCHOLOGY

# RECOD REQUEST FORM

*Please note that processing of record requests can take up to two weeks.*

**Requested by:**

Client Name: _____ Date of Birth: _____
Contact Number: _____
Address _____
*Street* *City* *Zip Code*

**Request for:**
__ Detailed receipt for flex-plan (*please provide dates of service*)
From: _____ To: _____
__ Medical Record
__ Other (*please explain*):

**Receive by:**
__ Email (*superbills only*)
__ Mail
__ Pick-up

Comments: _____

_____ _____
Client Name *(Please Print)* Date

_____
Client Signature

STAFF ONLY:

__ Authorization on file
__ Clinician Reviewed
__ Document signed

__ Sent on:
__ Sent by:

Comments: _____

CA Psychology, LLC
www.ca-psychology.com
mail@ca-psychology.com

Business Hours
Mon-Fri 8.00AM-8.00PM
Sat 8.00AM-1.00PM

P.O. Box # 8272
Honolulu, Hawaii 96830
United States