Southeast Kansas Mental Health Center

Personal Request for Medical Records

Today's Date: _____

Individual served Name: _____

Individual served DOB: _____

Chart Number: _____

Phone Number to contact once records are ready: _____
If emailed records are preferred we will not call.

Method of Receiving Records:

☐ **USB Drive ($7.00 fee)**

☐ **Email: _____**

☐ **Other: _____**

The purpose for my request is:

_____

The dates to be included in my record request are:

_____

_____

Please note: Medical record requests may take up to **30 days to process**. Requests may require additional time if records are extensive, require review, or need to be gathered from multiple sources. The individual served or authorized representative will be contacted when records are ready or if additional information is needed.

_____

Signature of Individual Served: **Date:**

_____

Signature of personal representative: **Relationship:** **Date:**