MIND24-7

An open door to mental health care, around the clock.

MIND 24-7 Medical Records Request Form

Please complete the following form in its entirety when requesting medical records for a patient who has or is receiving care from MIND 24-7.

Name of Requestor: *

First Name Last Name

Requestor's relationship to the patient: *

For example: Parent, Guardian, Provider, Case Manager, etc.

Requestor's email address: *

Please enter an email address in case we need to contact you. example@example.com

Requestor's phone number: *

Please enter your best contact phone number.

Preferred Method of Contact (Please let us know the best way to reach you if we have questions about your request.)

- ◯ Email
- ◯ Phone

Patient Name *

First Name Last Name

Patient Date of Birth: *

Month Day Year

STARTING Date of Service being requested: *

Month Day Year

ENDING Date of Service being requested: *

Month Day Year

Type of records needed: *

For example: discharge summary, psych eval, medical eval,etc.

How do you want to receive the information?

ONCE COMPLETE, PLEASE EMAIL THIS FORM TO MEDICALRECORDS@MIND24-7.COM.

If we have any questions about your submission, we will reach out to the contact information provided above. If you have any questions, please contact us by calling **844-MIND247 (844-646-3247)** or by emailing us at **medicalrecords@mind24-7.com**.