

SOUTHERN CRESCENT SEXUAL ASSAULT AND CHILD ADVOCACY CENTER

REQUEST FOR RECORDS



Please fill out the following form with the correct information about the individual you are requesting records for. Please send completed form to records@scsac.org. We will let you know when you can pick up the record/records. Please contact us to let us know when you will be picking up your records.

Date of request: _____

Individual Information

Name:		DOB:
Date seen at SCSAC-CAC:		
Please check which of the following you would like to receive:		
<input type="checkbox"/> Forensic Interview	<input type="checkbox"/> Forensic Medical Exam	<input type="checkbox"/> Counseling

PLEASE NOTE: Release of Counseling Records requires a subpoena.

Name:		DOB:
Date seen at SCSAC-CAC:		
Please check which of the following you would like to receive:		
<input type="checkbox"/> Forensic Interview	<input type="checkbox"/> Forensic Medical Exam	<input type="checkbox"/> Counseling

Requesting Agency Information

Name and Agency:
Number (best to reach you at):
Email:
Mailing Address:

Requesting Agency to Complete upon pick-up

Date request was picked up:
Picked up by (Print Name):
Signature:

SCSAC-CAC Staff Only

Collaborate Updates: Contacted RA for pick-up:

RA Pick-up Completed: