



Medical Records Request Form

Please complete the following information:

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

I authorize the custodian of records, or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- All Records Operative Reports
- Specific Date Range _____ to _____ Imaging: _____
- Other (describe specifically): _____

Please Note:

1. *If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of information.*
2. *Records obtained from prior treating doctors will be included in these documents.*

Method for receiving records:

- Mail to: _____ Fax to: _____ Picked Up: _____
- _____ Fax #: _____ (office location)
- _____

Reason for disclosure:

- Personal Worker's Comp Disability Attorney Transfer of Care Other: _____

I hereby request disclosure of the health information for the above-named patient. This request is only valid for the date of signature. I understand that after the custodian of records discloses my health, information, it may no longer be protected by federal privacy laws. My refusal to sign will affect my ability to obtain records. By signing below, I represent and warrant that I am the person above.

Patient/Responsible Party Signature

Today's Date

NOTE: NO CHARGE FOR THE FIRST 10 PAGES (*applies to records requested & supplied to patients only*), THEN \$0.50 PER PAGE UP TO 50 PAGES AND \$0.25 A PAGE THERAFTER FOR COPIES FROM PAPER **PLUS A \$10.00 PROCESSING FEE. ALL POSTAGE AND SHIPPING COSTS ARE INCLUDED.**

Requests for access to health records in an electronic format must be made in writing, dated, and signed by the requestor, identify the nature of the information requested, include evidence of the requestor's authority to receive access, identify the person to whom information is to be disclosed, and specify the preferred format. Within 15 days of receiving a request for access, the entity must take one of the following actions: Furnish the copies of or allow access to the requested records in electronic format, if requested; If the information does not exist or cannot be found, inform the requestor; If the entity does not maintain a record of the information, inform the requestor and provide the name and address of the entity that does maintain the record, if known; or deny the request.

FOR STAFF ONLY

Total Page(s) count: _____

First 10 pages at NO CHARGE

_____ pages at \$0.50 per page \$ _____

_____ pages at \$0.25 per page \$ _____

Processing Fee \$ _____

Total Amount Due: \$ _____

Date Received: _____

Processed by: _____

(Full Name)

Payment Method: Credit Card Cash

Check: (#) _____