TEXOMA FOOT AND ANKLE SPECIALISTS

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PATIENT RECORDS REQUEST FORM

Please complete the form by printing neatly. Processing time of 72 hours may be required.

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ SSN: _____

TYPE OF RECORDS REQUESTED:

- ☐ Face Sheet (demographics & info)
- ☐ Office Visit Notes
- ☐ X-ray image disc ($12 - $18)
- ☐ Information disclosure record
- ☐ Ledger and Payment History (more than 6 months old)
- ☐ Surgical Paperwork (preoperative visit to post-operative report)
- ☐ Insurance payment explanations
- ☐ Initial patient paperwork, forms signed, etc.
- ☐ Other (please specify): _____

_____

TIME PERIOD REQUIRED: _____ to _____ OR ☐ ALL records of this type

PURPOSE OF RELEASE: _____

Please be advised that if your records are jointly combined with another patient on any type of report (for example, insurance payment explanations), you will only be provided with the segment which applies to you so as to protect the privacy of other patients. While you are able to review your records at no charge, copies and or x-ray discs are subject to **a fee of up to $30.00** as determined by our office. By signing this form, you agree to be financially responsible for this fee. Fees must be paid at the time records are rendered.

HOW DO YOU WANT TO RECEIVE THE DOCUMENTS? (X-ray images are on CD and can only be mailed or picked up.)

☐ Pick up in office ☐ E-Mail to: _____

☐ Mail to: _____

_____

_____

_____

Phone: _____

☐ Fax to: ( )_____ - _____

Attn: _____

Organization: _____

Phone: _____

_____
SIGNATURE (If legal guardian, print name as well)

_____
DATE OF REQUEST/ SIGNATURE

OFFICE USE – DO NOT WRITE BELOW THIS LINE

RECORDS SENT VIA _____ AT _____ : _____ AM/PM ON ____ / _____ / _____ BY _____