TEXOMA FOOT & 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: _____

FEES FOR RECORDS:	
Copies	**$1.00 first page, $0.50 per additional page**
X-ray disc	**$8.00 per day of x-rays up to $20.00 maximum**

TYPE OF RECORDS REQUESTED:

☐ Office Visit and Surgical Notes ☐ X-ray image disc
☐ Billing records ☐ Information disclosure record
☐ 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 **fees as indicated above**. 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: _____ ☐ Fax to: ( )_____ - _____

_____ Attn: _____

_____ Organization: _____

Phone: _____ 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 _____