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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 ☐ HIPAA Information Disclosure record

☐ Billing Records ☐ Explanations of Benefits from Insurance payments

☐ 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 the segment which applies to you so as to protect the privacy of other patients. Information relating to other patients may be redacted. While you are able to REVIEW your records at no charge in our office, 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 before 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: _____

_____ _____

SIGNATURE (If legal guardian, print name as well) DATE OF REQUEST

RECORDS PROVIDED ON DATE _____/_____/_____ AT _____: _____ AM/PM BY _____