

Request for Copy of Medical Records

Patient Name: _____

Birthdate: _____ ID#: P00_____

SS#_____

I request a copy of my medical records. The information I want is: _____

I understand that there is a fee of \$0.15 per page for records longer than five pages, except there is no charge for copies of immunization records or TB skin test results. I understand that there is a \$5.00 fee for mailing. I understand that all fees must be paid in advance.

Please do or do not (circle one) mail me the records.

Under certain circumstances, we may deny a request for records. If this occurs, we will notify you in writing within thirty days. If you would prefer to be notified by phone, please initial here: _____. We will also provide you with a written explanation for the denial, and an explanation of how you can appeal.

Signature_____ Date: _____ Phone:_____

Mailing Address: _____

To be completed by Privacy Contact , Privacy Officer or Medical Records Staff Member

Date of receipt: _____

Circle one: Request denied
Records faxed

Records mailed

Records picked up

Date records provided or denial letter sent: _____

Charge: _____

Staff Signature: _____

Date: _____