

Patient Records Request Form

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Name of Patient Whose Record is Requested _____

Date of Birth _____ Phone _____

Address _____ City/State/Zip _____

Please provide a copy of the record maintained by this provider/practice

The full health record maintained by this provider/practice

The health record for the following time frame: _____ through _____

A specific section of the health record as described below: _____

A summary of the information requested above is adequate to fulfill this request.

As permitted by federal and state law, I understand that a fee of _____ per page will be charged for copying the records along with a clerical fee of _____. In addition, a fee of _____ will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive the copy of the record.

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____