

All the information requested on this form must be completed to process your request.

REQUEST FOR PATIENT ACCESS TO RECORDS FORM

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Social Security#: \_\_\_\_\_ - -

Previous Names used by patient: \_\_\_\_\_

Patients Address: \_\_\_\_\_

Treatment Dates: From: \_\_\_\_\_ To: \_\_\_\_\_ Contact Phone: \_\_\_\_\_ Today's Date: \_\_\_\_\_ - -  
(It is very important that the treatment dates be filled out exactly.)

I Authorize: \_\_\_\_\_  
 to release my records to: \_\_\_\_\_  
You must complete one form for each entity to whom you want information released.

<p><b>Where do you want your records to go?</b>                  Name of Recipient: _____                  Address of Recipient: _____                  Street: _____ P.O. Box _____                  City: _____ State: _____ Zip: _____</p>	<p><b>How do you want the information To be transferred?</b>                  (Check the Box That Applies)  <input type="checkbox"/> Mail <span style="margin-left: 100px;"><input type="checkbox"/> Pick-up</span>                  Phone Number: _____                  (For Recipient)</p>
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<p><b>The type of access requested is:</b>                  (Please check only the boxes you require.)</p> <p><input type="checkbox"/> <b>Complete Chart</b>      <b>ATTENTION:</b>                  There is a fee for a copy of the complete chart. This cost varies by the size of the record copied.                  Records 1-25 pages cost _____,                  26-100 pages cost _____.</p> <p><input type="checkbox"/> <b>Personal inspection of medical record.</b>                  (By appointment only)</p> <p><input type="checkbox"/> Operative Report(s)    <input type="checkbox"/> Emergency Reports  <input type="checkbox"/> Discharge Summary    <input type="checkbox"/> Radiology Report  <input type="checkbox"/> Clinic Reports            <input type="checkbox"/> Laboratory Reports  <input type="checkbox"/> Consultation             <input type="checkbox"/> Billing  <input type="checkbox"/> Pathology Reports  <input type="checkbox"/> History &amp; Physical  <input type="checkbox"/> Other (Please List)</p>	<p><b>FOR THE PURPOSE OF:</b></p> <p><input type="checkbox"/> Further Treatment    <input type="checkbox"/> Insurance Claims  <input type="checkbox"/> Workers Compensation    <input type="checkbox"/> Legal Request  <input type="checkbox"/> Personal Records  <input type="checkbox"/> Other (Please List)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>I request this access as: (check one)                  (Must furnish appointment papers for all except Patient and Parent of minor patient.)</p> <p><input type="checkbox"/> Patient    <input type="checkbox"/> Parent of Minor Patient    <input type="checkbox"/> Guardian of Patient or Resident  <input type="checkbox"/> Conservator of Patient    <input type="checkbox"/> Beneficiary of deceased patient  <input type="checkbox"/> Attorney-in-fact under durable power of attorney for healthcare  <input type="checkbox"/> Personal Representative of deceased</p>
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Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Today's Date: \_\_\_\_\_

I have read and understood this Consent in its entirety. \_\_\_\_\_(Initials)