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REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Our office has 30 days to process patient's request for medical records.

Today's Date: _____ Patient's Name: _____

Patient's Birth Date: _____ Chart #:_____ Patient ID # _____

Patient's Address: _____

Phone Number (H): _____ (W): _____ (C): _____

I understand and agree that I am financially responsible for the following fees associated with my request. In a 12 month period, the **first copy will be free**. All copies thereafter will be $25 for copying charges, including the cost of supplies, labor and postage related to the producing of my information. I understand that I may inspect my records within 30 days after the request and may do so between the hours of 8:00 a.m. and 5:00 p.m. Mondays thru Fridays.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient or Personal Representative

_____
Personal Representative's Authority or Relationship to Patient

Office notes ☐

MRI Report ☐

CD – MRI ☐

CD – X-rays ☐

Other : _____

MRI

Referring Physician: _____

Scan Date: _____

Scan Performed: _____

_____

Please Mail ☐ Pick-up (Please Call) ☐ Electronic (CD) ☐

Delivered / Picked up _____
Date Int.

Date: _____
Patient has been notified □
Left a message for patient □
Wrong / non-working phone number □