

## REQUEST FOR PATIENT ACCESS TO MEDICAL RECORDS

I hereby request (name of physician, hospital or other healthcare provider) \_\_\_\_\_, to give me access to medical information for (patient's name) \_\_\_\_\_.

### SCOPE OF ACCESS REQUESTED

I would like access to:            **G** All the records *or*  
    **G** The portion of the records concerning: \_\_\_\_\_

(Specify type of disease, accident, dates of treatment, other portion of records you are interested in.)

### TYPE OF ACCESS REQUESTED

**G**     **Inspection.** Please call me and let me know when I may come to inspect the records, and the amount of the charge, if any.

**G**     **Copies.** I would like copies of                     **G** All records requested *or*  
    **G** All records other than X-rays or tracings

**G**     **Transfer.** Please transfer                        **G** Copies of all records requested *or*  
    **G** Original X-rays or tracings only

To: \_\_\_\_\_  
(Name and address of health care provider to whom the records are to be delivered)

### CHARGES

**Inspection.** I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection.

**Copies or Transfer.** I understand that you may charge me a reasonable charge of up to twenty-five cents (\$0.25) per page, or fifty cents (\$0.50) per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available. I further understand that you may charge me your actual costs for copies of any X-rays or tracings derived from electrocardiography (E.K.G.), electroencephalography (E.E.G.) or electromyography (E.M.G.).

**G**     I hereby agree to pay the charges specified above. Please bill me.  
**G**     Please call me to let me know how much this will cost.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- G**     parent or guardian of minor patient
- G**     guardian or conservator of an incompetent patient
- G**     beneficiary or personal representative of deceased patient

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