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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