Medical Records Request as allowed by State and Federal Law

PATIENT INFORMATION

Name _____ Date of Birth _____ SSN _____

Mailing Address _____

Email Address _____

Phone Numbers: Cell _____ Home _____ Work _____

REQUESTOR INFORMATION (if different from patient, proof of authorization from the patient must be attached such as a power of attorney)

Name _____

Mailing Address _____

Email Address _____

Phone: Cell _____ Home _____ Work _____

DOCUMENTS REQUESTED

Medical practice name: _____

Doctor or other provider name: _____

Dates of service: _____

Documents requested: _____

RECIPIENTS: Name and Destination (email address, / fax # / us postal address)

_____

_____

_____

CHARGES

Fulfilling records requests incurs a cost upon practices (e.g. scanning, filing, storage, search, reproduction, computer hardware costs, software license and subscription fees, staff time, and liability for breaches). These costs are not included in the charges for the actual healthcare services delivered. Thus, state and federal laws specify allowed charges for medical records. Requests for records will only be charged the amount allowed by law. Please refer to the website for the state where you received healthcare services to determine your actual costs. e.g. Maryland: $30.48 plus mailing for 10pgs in Dec 2013 http://www.mbp.state.md.us/pages/faq_records.htm

PAYMENT INFORMATION:

State where healthcare services were received: _____

Credit Cardholder Name: _____, Card Number: _____

Security Code (4 digits on front of AmEx or 3 digits on back of Visa /MC) ____ Expiration: _____

If mailing a check, only pages covered by the check will be sent. See State website for charges.

By signing below, I hereby authorize the above release of medical records and agree to pay the above legally allowed amounts with the above listed credit card. I understand that email is not secure and agree to hold the health care practice along with their employees, agents, owners, contractors, and providers and any other persons or entities harmless for any loss of confidentiality from my request.

_____ _____ _____

Printed Name of Requestor Signature of Requestor Date Signed

Please mail or fax this request to the Practice from whom records are being requested.

Incomplete or invalid requests will not be sent a response unless required by law. All requests will be charged as allowed by law. The above policy is subject to change without notice as required for compliance with changing laws.