

# UNIVERSITY ORTHOPAEDIC CLINIC AND SPINE CENTER

## Policy 9

### FORM REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient Address \_\_\_\_\_ Last 4 digits SSN: \_\_\_\_\_  
Street \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Chart # \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Cell # \_\_\_\_\_

I would like to request a copy of my medical record, and I know that I am responsible for copying charges (cost of supplies and labor) and postage. There is a \$5.00 deposit which must be paid at the time of the initial request. The remainder of the fee must be paid prior to receiving the requested records.

I wish to request the following medical records:

\_\_\_\_\_ All medical records for treatment by UOC Providers  
\_\_\_\_\_ Medical records for treatment by UOC Providers from date of service \_\_\_\_\_  
to date of service \_\_\_\_\_  
\_\_\_\_\_ Records as Specified \_\_\_\_\_

Please state reason for request \_\_\_\_\_

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I agree to pay the non-refundable deposit prior to receiving the records and understand that the records will be available within thirty (30) days of my written request or notification of any delay. Prior to receipt, I will pay any remaining fees.

\_\_\_\_\_  
Signature of Patient or Legal Guardian Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian Chart #

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