

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: _____

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:

___ Any and All Medical Records (ENTIRE CHART)

OR As Indicated Below:

___ Progress Notes from Dr. _____ and Dr _____ or ___ All UOC Physicians

___ Date of Service _____ to _____

___ Specific Request: _____

___ Itemized Statement: Patient Balance must be paid prior to receiving itemized statement.

Please state reason for request _____

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.

Patient Signature or Personal Representative Date

Print Name of Patient and Name of Personal Representative (if applicable) Medical Record #

As a Personal Representative, I have authority to act for the individual because I am:
