



REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Our office has 30 days to process patient's request for medical records.

Today's Date: _____ Patient's Name: _____

Patient's Birth Date: _____ Medical Record #: _____

Patient's Address: _____

Phone Number (H): _____ (W): _____ (C): _____

I understand and agree that I am financially responsible for the following fees associated with my request. In a 12 month period, the **first copy will be free**. All copies thereafter will be \$25 for copying charges, including the cost of supplies, labor and postage related to the producing of my information. I understand that I may inspect my records within 30 days after the request and may do so between the hours of 8:00 a.m. and 5:00 p.m. Mondays thru Fridays.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Personal Representative's Authority or Relationship to Patient

Office notes

MRI Report

CD – MRI

CD – X-rays

Other : _____

MRI
Referring Physician: _____
Scan Date: _____
Scan Performed: _____

Please Mail Pick-up (Please Call)

Delivered / Picked up _____
Date Int.