

Request to Inspect or Obtain Copy of Patient Records

This form is to be used when a patient requests to inspect or obtain a copy of his/her own medical or billing record. This form should <u>not</u> be used to send records to a third-party (use the Authorization for Use and Disclosure of Protected Health Information Form).

City: State: Zip Code: Inspect: I would like to inspect a copy of my medical or billing records. Please contact me to arrange a time Obtain: I would like to obtain a copy of my below records: Consultations Progress Notes Laboratory Reports X-ray or Imaging Reports X-ray or Imaging Films/Images Discharge Instructions Billing Records Billing Records Consultations Billing Records	Patient's Lega	al Name:		
Inspect: I would like to inspect a copy of my medical or billing records. Please contact me to arrange a time Obtain: I would like to obtain a copy of my below records: Examination Notes Progress Notes Laboratory Reports X-ray or Imaging Reports X-ray or Imaging Films/Images Billing Records Entire Chart Other: (describe) Format: paper copy or electronic copy Delivery: I will pick up the records. Please call me when they are ready. Please send the records to me: Mail to my home address on file email to my email address on file. *I understand that transmission by email ma unsecured and accessible by third-parties during transmission. I have been warned of the risk and request USRS to proceed. Signature of Patient/Personal Representative* Date INTERNAL USE ONLY	Address:			DOB:
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Attorney)INTERNAL USE ONLY	Signature of F	Patient/Personal Representativ	e*	 Date
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Date payment received (if applicable) Amount receivedCheck Cash CC	Date payme	ent received (if applicable)	Am	ount receivedCheck Cash CC
Date records sent Sent By	Date record	s sent Sent B	у	