REQUEST FOR RECORDS

NAME OF PATIENT ____
Date of birth: ____
[Other identifiers as desired by TPCHD ____________________________________

IF YOU ARE NOT THE PATIENT:

What is your name? ______________________________________
Your relationship to patient: ______________________________________

What gives you authority to receive the patient's information:

______ Written patient authorization (please attach)
______ You are the patient's parent or guardian (please attach evidence)
______ You are the patient's health care decision maker (please attach evidence, such as a medical power of attorney)
______ The patient is deceased, and you are the personal representative of the patient's estate (please attach evidence)
______ Other (please explain): ______________________________

INFORMATION REQUESTED

______ Medical records for visits dated: ________________
______ Billing records for visits dated: ________________________
______ A summary of medical records (patient history and nurse progress notes for each visit) for visits dated: ____
____
______ A summary of billing records (cover page of the patient billing statement for visit visits dated: ____
____
______ Other: Explain ____

CHARGES FOR INFORMATION

I understand that I may be charged for the copies as follows:

- ✓ Medical Records Retrieval and File Copy rates:
  - **$25.00** Retrieval fee
  - **$1.12** per page photocopy charge for the first thirty pages
  - **$0.84** per page photocopy charge for all other pages
- ✓ Billing records will be copied at a charge of **$0.15** per page.
- ✓ ______________________________[Insert charges for other reports].

- Official Copy of Immunization Record without Vaccine Administration ▪ 10.00
- Certification Letter of Tuberculosis Treatment for Employment ▪ 10.00
- Record of PPD Results ▪ 10.00
- Hepatitis Screening Results Letter ▪ 5.00
- Computer Printout of Immunization Records without Vaccine Administration ▪ 5.00

✓ All information mailed will be subject to postage or other delivery fees.

✓ Non-Sufficient Funds (NSF) check charge $35.00

METHOD OF DELIVERING INFORMATION:

______ I will pick up the records at ____
(Insert Program Location)

______ Please mail the records to me at ____________________________________
____
____

______ I will review my original records onsite in the ____________________________.
(Insert Program Location)

______ I will call the TPCHD to arrange a time to do so, at phone number __________.

I am authorized to receive copies of the medical and billing records for (insert patient's name)

____. I understand that I may be charged as set forth above for the copies of records I have requested and for postage, if needed, and I agree to pay the total charges prior to my receiving the copies.

____
Signature

____
Print Name

____
Date