

Request for Medical Records

Patient Name: _____

Date of Birth: _____ Account #: _____

Address: _____

I authorize Batavia Foot Care Center to take the following action:

Obtain my protected health information from: Release my protected health information to:

Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

For this authorization, "my protected health information" means:

- | | | |
|--|---|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> History and physical | <input type="checkbox"/> Hospital reports |
| <input type="checkbox"/> Lab/pathology reports | <input type="checkbox"/> Medications | <input type="checkbox"/> Operative reports |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Radiology reports/images | <input type="checkbox"/> Other: _____ |

Date(s) of service requested: _____

For my healthcare treatment At my request Other: _____

I understand that:

(1) This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not. (2) This authorization is valid for one year from the date signed unless an earlier date is specified here: _____ (3) I may revoke/withdraw this authorization at any time by providing written notice; however, revocation/withdrawal will not apply to any previous release information. (4) Once my protected health information is disclosed as requested, it may no longer be protected by federal and state privacy laws. (5) The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug, and alcohol abuse, etc. (6) There may be a fee for a copy of my protected health information. I agree to pay this fee.

Patient Signature or Personal Representative: _____ Date: _____

Patient Name or Personal Representative: _____ Relationship to Patient: _____

Charge Applied for release:
\$.75 per page: _____ pages = \$ _____
\$5.00 X-Ray Disc (if requested) \$ _____