PATIENT REQUEST FOR A COPY OF MEDICAL RECORDS

This is a request to obtain a personal copy of your medical records or to have a copy of your records sent to another physician. This request is for your paper records only. If you would like radiology films, please let the front desk staff know and they will contact a member of the radiology staff to assist you.

THIS REQUEST WILL TAKE APPROXIMATELY 7-10 DAYS TO COMPLETE.

Patient Name: ___________________________________ Social Security Number: _____________________

Address: ___________________________ City: ________________ Zip: ____________State: ____________

Date of Birth: ____________________ Home Phone: _______________________ Work Phone: __________

POC Physician Seen: ____

DESCRIPTION OF HEALTH INFORMATION BEING REQUESTED:

☐ Complete medical record (Please specify dates of service) ____

☐ Partial medical record (Please specify dates of service) ____

RECEIVING PARTY INFORMATION : ☐ **Patient** ☐ **Physician** ☐ **Other:**______________

Name: ____

Address: ____

City: _______________________________________ State: ___________________Zip Code: _____________

Please note that effective August 1, 2005 there will be a charge to complete all patient requests for a copy of their medical records. Per the Office of Planning and Budget for the State of Georgia the fee schedule for this service is as follows:

- Copying Costs — $0.93 per page for pages
$0.80 per page for pages 21-100
$0.63 per page for pages over 100
- Postage — Actual postage costs

Peachtree Orthopaedic Clinic utilizes a company to complete our medical record requests. Discovery Support Services will send you an itemized bill along with the copied records. If you have any questions as to the bill or the status of your request, you may contact them at: 678.990.5300. All requests will be mailed to the patient's home address.

If you are requesting that a copy of your records be sent directly to a physician's office involved in your medical care, then this is provided at no-cost as a courtesy. These records will be sent to a verifiable address for the physician listed.

I understand that I will be billed by Discovery Support Services for the charges incurred in processing my request and agree to pay any and all charges in full: ____

Patient Signature Date