

TYPE OF ACCESS REQUESTED

- Inspection.** Please let me know when I may come to inspect the records. I understand that an employee of this medical practice may be present during the inspection and that I may not make any marks or alter the records in any way.
- Copies.** I would like copies of the information requested. I understand that I may be charged a fee for the copies as explained below. Please mail to:

(Please print clearly)

- Written summary.** I would like a written summary of the information requested. I understand that I may be charged a fee as explained below.

CHARGES

Copies. I understand that you may charge me a reasonable fee of up to \$0.45 per page, including any research fees, handling fees and the cost of first class postage, if applicable, for copies of the information requested. (There is no charge for copies totaling \$5.00 and under, or 11 pages or less.)

X-rays. I understand that I may be charged a fee as necessary to cover the cost of materials for providing a copy of x-rays. The minimum cost for x-rays is \$25.00 for the first 5 copies and \$7.00 for each additional copy thereafter, plus handling fees of first class postage should mailing be necessary.)

- I hereby agree to pay the copying charges specified above.
- Please call me and let me know how much these copies will cost and to arrange payment.
- I am requesting these records be provided without charge because they are requested for the purposes relating to a claim or appeal under a provision of the Social Security Act. Documentation of the claim or appeal is attached.

Written Summary. I understand that I may be charged a fee of _____ for the cost of preparing the summary requested.

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate your relationship to the patient. _____

MEDICAL RECORDS WILL BE RELEASED UPON RECEIPT OF YOUR PAYMENT. THANK YOU.