AU Medical Center

Patient Request to Inspect or Obtain Copy of Health Information

Patient Name:	Patient Number:
Date of Birth:	Social Security Number:

Request Date: _____ **Current Inpatient:** ☐ **Yes** ☐ **No**

I request ☐ to inspect ☐ to receive a copy of the above named individual's health information as described below, concerning the period from _____ to _____.

☐ Medical Information, as specified:

☐ Standard Document Set (Discharge Summary, History and Physical, Progress Notes, Test Results, Consults)

☐ Other (specify) _____

☐ Psychiatric/Psychological Information/Substance Abuse ☐ Patient Accounting/Billing Information

Special instructions: _____

_____

I understand that there may be a fee for this request and wish to proceed. I also understand that an appointment for inspection or the requested copies will be provided to me within 30 days unless I am notified in writing that an extension of up to 30 days is needed. I understand that for records maintained off-site, it may be 60 days.

Please note: Record copies that are not picked up within seven (7) business days from the date of request will be mailed to the requester and billed accordingly.

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

The fee for this request will be: _____

**********FOR OFFICE USE ONLY**********	
Credit Card (Last 4 digits ONLY)	
Check Number	

PRIVINSP