Ancor Pediatrics, PA

REQUEST TO INSPECT OR COPY RECORDS

Date: _____

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Phone: ( ) _____ DOB: _____ SSN: _____

REQUEST INFORMATION

☐ Inspect Records ☐ Copy Records ☐ Inspect/Copy Records

Records Requested: ☐ Entire Record ☐ Lab ☐ X-Ray ☐ Progress Notes

☐ Hospital Records ☐ Other: _____

Special Information: ☐ Substance Abuse ☐ Psychiatric/Mental Health Information ☐ HIV Information

Reason for Request: ☐ Personal Use ☐ Consultation

☐ Other (Please Specify): _____

FEES FOR COPYING

If you wish to obtain copies of any of the requested information, we will arrange to copy and send it to you. We will charge a fee of $25.00 for the first 20 pages and .15¢ per page thereafter. Payment in full is required before records will be copied. You may either pick up the copies when they are ready, or we will send them to you. If we send them to you, you will be charged for the actual mailing cost based upon the delivery method you request (for example, first class mail, overnight delivery, etc.).

Within the limitations of the law, we will make every effort to accommodate your request.
We will complete our review of your request and either arrange for you to inspect your records within 30 days, or provide you with a written explanation of any restriction on the information that we can provide you.
If we delay your request, in whole or in part, you may request that we review that decision.
THIS REQUEST AUTOMATICALLY EXPIRES THIRTY (30) DAYS FROM THE DATE OF MY SIGNATURE

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian/Relationship to Patient Witness

FOR OFFICE USE ONLY:

Approved: _____ Denied: _____ FEE AMT: _____ PAID: YES____NO____

Date and time of records inspection:

_____