Medical Records Request/Release

Date of Request: ____________________
mm/dd/yy

Patient: ____
Last First DOB (mm/dd/yy)

Requesting Party (if different than patient): ______________________________
Last First DOB (mm/dd/yy)

Relationship to Patient: Parent/Guardian Spouse Attorney Other: ______________________
Please Specify

I am requesting a copy of my, or a patient which I represent, medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations. I, or the patient I represent, was treated in your office, Physical Therapy Specialists (PTS), between the dates of:

_____________ through _____________ or ☐ I am unsure of the dates I, or the person I represent, attended
mm/dd/yy mm/dd/yy

I wish to receive copies of the following health records related to my treatment:

☐ All Records

☐ Daily Notes

☐ Evaluations, Re-Examinations, Progress Notes, & Recertification Notes

☐ Billing Records

☐ Other: ____

Under HIPAA Section 164.524, I can be charged a reasonable fee for copying records. I may also be charged for postage if I ask that records be mailed to me. HIPAA allows 30 days for a provider to respond to my request for records, with one 30-day extension for good reason. In accordance with California Health & Safety Code Section 123100, a record preparation fee of $4 plus $0.25/page will be charged. Government issued photo ID will be required of the individual picking up records.

Please specify how you wish to receive your records:

☐ I wish to pick up my records in person

☐ I wish to release my records to:

☐ Alternate Party: ____

☐ I wish to have my records faxed to:

☐ Physical Therapy Specialists at (805) 473-7494

☐ Other: ____

Total Pages Printed: ___________

Requesting Party: ____________________________________ Preparation Fee: $ 4.00

Payment Date: ____________ Postage: $____________

Payment Accepted by: _____________ ☐ Cash ☐ CK #: _______ ☐ CC **Total Due:** $____________
Employee Initials