MEDICAL RECORDS REQUEST FORM

I, _____, hereby request that Ron French, OT, CHT provide:
(Patient or parent/guardian)

□ Complete medical records from dates: _____ to _____

□ Pertinent medical records as evaluation/progress notes/tests

For:
Patient's name: _____ Date of birth: _____

Address: _____

City/ST: _____ Zip: _____

I am requesting that the records identified above be handled in the following manner:

□ Mail to address listed above □ Fax Number/Attn: _____

□ I will pick-up □ A representative will pick-up on my behalf (Name) _____

□ Other: _____

Mail information to: □ Clinic □ Dr. Office □ Hospital □ Attorney □ Other_____

Address: _____ Phone: _____

City/ST: _____ Zip: _____

Individual Rights: I may refuse to sign this Authorization. I may revoke this authorization at any time. My revocation must be in writing and signed by me. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others may have already acted in reliance upon this authorization. I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the health information that I am being asked to disclose.

I understand there may be a charge for medical records. Not to exceed $18.00 for first five pages and up to $0.85 for pages 6-50, $0.51 for pages 51-250 and $0.35 for each additional page plus any applicable mailing fees. Estimated charges (if known): _____

_____ _____
Signature of patient, parent, or guardian Date

_____ _____
Print Name (Relationship if signed by other than patient)

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected.)