SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

Medical Records Request & Payment Form

PATIENT:

Name: _____ DOB _____ Phone: _____

Address: _____

INFORMATION TO BE DISCLOSED:

I request copies of my medical records be provided.
Date range to be released: _____
or
Specify exact information to be released: _____

I understand there is a fee as outlined below:

Less than 10 pages – No Charge
Over 10 pages - $0.42 per page to a maximum of $50

PATIENT AUTHORIZATION:

I hereby authorize information in my medical records to be released and mailed to the address above.

Patient Signature: _____ Date: _____
(Patient, Guardian or Authorized Representative)

Please charge my credit/debit card, I understand that the charge will not be specified until all work is completed and will not exceed $50.

VISA _____ MASTERCARD _____ DISCOVER _____ AMEX _____

Cardholder Name: _____ Credit Card # _____
Cardholder Signature: _____ Exp. Date: _____ Security Code: _____
Billing Address: _____ City: _____ State: ____ Zip: _____

Failure to fill out all sections will delay your request.
*Allow up to 30 days for processing, as acceptable by law. *Most requests completed within 10 business days.*

Medical Records Services Provided By: Med Request Solutions Inc. 1 800-483-6040