

PATIENT RECORDS ACCESS REQUEST FORM

I hereby request a copy of my medical record as detailed below:

- All treatments rendered in AICD Offices
- Medical record for the period of _____ through _____
- A specific section of the medical record as follows:

I understand there will be no charge for this if the request is for less than 5 pages and \$.50 per page for over 5 pages. The charge for copies of nuclear images is \$10.00. The charge for vascular images is \$10.00. The charge for copies of an echocardiogram tape is \$25.00. I agree to pay the charge in full at the time I receive my copies of my medical record. I understand that this request will be processed within 7-14 days except in the emergency.

Print Patient name:(please print)_____ Date of birth:_____

Mail records to:

City:_____ State:_____ Zip Code:_____

Signature:_____ Date:_____

Administrative Use Only:

Date completed:_____ By:_____

Charge: \$_____

I acknowledge that I have received copies of my medical records as requested above.

Signature of patient

Date:_____