REQUEST FOR MEDICAL RECORDS

PATIENT REQUEST FOR THE RELEASE OF MEDICAL RECORDS

I, the undersigned Patient (and/or Legal Representative), would like to review following patient records (Specify the patient name and a description of the records requested (including any applicable dates):

Patient Name: _____

Description of records requested: _____

_____

⏭ I would like copies of these records. *

⏭ I would like copies of my records sent to the following address:

_____

_____

_____

Signature: _____ Print Name: _____ Date: _____

If someone other than the patient requests access to patient records, please describe below the relationship of the requestor to the patient:

_____

_____

_____

In accordance with the SC Code § 44-115-80, there is a one time clerical fee of Twenty Five Dollars ($25.00), plus Sixty Five Cents ($.65) per page (1-30); fifty cents ($.50) per page (31 +) not to exceed One Hundred Fifty Dollars ($150.00), plus actual postage and applicable sales tax. There is also an extra fee for special mailing requirements. All requests must be sent to the Central Business Office to the attention of Barbara Vitiello/Kristina Wolf Medical Record Clerks for processing. If you have any questions please call Barbara at 631/580-5200.

Treatment Location: _____