September 27, 09

NAME OF PRACTICE
NAME OF DOCTOR
ADDRESS
CITY STATE, ZIP

ATTN: MEDICAL RECORDS DEPARTMENT
Re: Your Name
Date of Birth: 00/00/0000
SSN: 000-00-0000

Dear Sir or Madam:

I am requesting a copy of all of my medical records for medical future care. Please provide all records you maintain pertaining **YOUR NAME**, for all dates of service.

RECORDS CUSTODIAN: Please forward a complete copy of your records regarding any and all treatment rendered to **YOUR NAME** for all dates of service. A complete copy consists of everything in the entire file from cover to cover (i.e. note/piece of paper you have, prescriptions, intake forms, dictated notes etc).

Per Arizona law (see below) there should not be a charge for these records. I am enclosing a medical authorization form. ALL PRIOR AUTHORIZATIONS ARE HEREBY REVOKED AND CANCELLED.

> *Arizona law (A.R.S. §12-2295) states that a healthcare provider or contractor may charge a person who requests medical records a reasonable fee for the production of the records. However, you may not charge the following people for medical records:*
>
> - *Another health care provider or contractor providing continuing care*
> - *The patient for the demonstrated purpose of obtaining health care*
> - *The health care decision maker or surrogate of the patient to whom the medical records pertain for the demonstrated purpose of obtaining health care*
> - *The Arizona Medical Board, an officer of the department of health services or the local health department.*

If you have any questions concerning these requests, please do not hesitate to give me a call.

Sincerely

YOUR NAME

Enclosure: HIPAA Compliant Medical Authorization

YOUR NAME
YOUR ADDRESS
YOUR PHONE

HIPAA COMPLIANT
AUTHORIZATION TO COPY MEDICAL RECORDS

To:
NAME OF PRACTICE
NAME OF DOCTOR
ADDRESS
CITY STATE, ZIP

<u>YOUR NAME</u>, social security number: **<u>xxx-xxx-xxxx</u>**, date of birth: **<u>xx/xx/xxxx</u>**, hereby authorizes and directs this healthcare provider (Provider) shown above to make available for copying all medical records pertaining to the **YOUR NAME** including but not limited to treatment, hospitalizations, evaluations, testing, and surgeries. This includes all files or records for all injuries or conditions in Provider's possession or under Provider's control that is held for any purpose. Nothing shall be removed, deleted, altered or withheld. Additional information to be disclosed by Provider if the box is checked:

_____ All billing records showing all charges, expenses, costs and payments.
_____ Original x-ray films.
_____ Drug and alcohol abuse testing, evaluation and treatment.
_____ Mental health information consisting of but not limited to all notes, records and reports of psychotherapy diagnosis, evaluation and treatment.
_____ Human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

At the request of the Individual above, this information will be used for additional medical purposes.

***Redisclosure**:* The items released may no longer be protected under HIPAA regulations once it has been used for the above-referenced purpose due to redisclosure.

The Individual has the right to refuse to sign this authorization. The Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether the Individual signs the authorization. This authorization is to expire one year from the date signed.

DATED: ____________________ ______________________________
Patient's Signature