



PATIENT REQUEST FOR MEDICAL RECORDS

Patient's Name: _____

Physician's Name: _____

Records should be delivered to: _____

Information/Records Requested: _____

I understand that I have the right to access my medical records in accordance with the law and the policies of Colon & Rectal Specialists, Ltd. I understand that Colon & Rectal Specialists, Ltd. may charge me for copies of my medical records, and I have been provided a fee schedule.

I understand that Colon & Rectal Specialists, Ltd. has the right to deny me access to my medical records in certain circumstances in accordance with the law. If the practice denies me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that the information disclosed pursuant to this request is no longer under the control of the practice and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of patient: _____ Date: _____

Patient Representative: _____ Date: _____

Relationship to patient: _____