HORIZON
VASCULAR SPECIALISTS

Medical Record Request Form

Notice to patient: Use this form to obtain a copy of records maintained about you. This type of request is described in our practice's Notice of Privacy Practices. I understand that there will be a nominal fee for obtaining a copy of my medical records and that fees charged will be in compliance with applicable Maryland law. I agree to pay this fee.

Patient Name_____ **Date of Birth** _____
(printed)

Signature of Patient _____ **Date** _____

Description of Records Requested:
(Please describe the types of records requested. Please indicate the dates for which you are requesting records.)

_____
_____
_____
_____

Records to be:

☐ Picked Up

☐ Mailed (USPS) to Name/Address below:

_____
_____

☐ E-mailed _____

☐ Faxed _____

*Printed Records: $0.76 per page, plus applicable postage

**Electronic Records (e-mail/fax): $0.57 per page (Not to exceed $80.00)

***Images on Disk: $19.86

(INTERNAL OFFICE USE)

See telephone encounter to determine which specific records were sent.

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative Relationship (parent, guardian, medical power of attorney, etc.): _____

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____

Date: _____