Signature™ HEALTH

MEDICAL RECORDS REQUEST & FEES

Date of Request: _____/______/__________

Patient Name: ____

Patient Date of Birth: _____/______/___________

Patient Phone Number: (________) ____________________

Reason for Records: ____

Dates of Service Requested: ____

Send Records To: ____

Fax Number*: (____) _________________ Phone Number*:(____)______________________
*Fax number where records are to be sent *Phone number of party receiving records

I have requested records for the above client and agree to pay any charges that accompany this request.

Sign Here: ______________________________________ ________________________
Signature of Patient/ Patient's Legal Representative *Relationship to Patient*

For Staff to Complete:
Staff Member Submitting form (if any):____
Is Release of Information signed if required?: Yes / No

FEES: Persons requesting records will be charged the following fees. No fees are charged when a patient or patient's personal representative requests records under Ohio Revised Code 3701.741(C)(1).

Fees payable upon delivery/pickup.

Paper Records Fees:

Pages:	Fees:
1-10	$ 0.50 per page
11-50	.25 per page
51 or more	.10 per page

Electronic Records Fees:

Pages:	Fees:
Any number	$6.50

Total: $______________________________ Paid on:_________________

*****Return this form to the Medical Records Department or the Front Desk of Any Location******

Fax: 440-269-2551 Email: sh-medicalrecords@shinc.org
Signature Health Inc. - 7232 Justin Way, Mentor, OH 44060