DUBLIN PRIMARY CARE

B·A·C·T·E·S
PEOPLE · PROCESS · TECHNOLOGY

BILLING STATEMENT for COPIES of MEDICAL RECORDS

Name of Patient:_____Medical Record Number (MRN)_____

Address where information can be sent: _____

_____

Thank you for contacting us for a copy of your medical record. We value you as a patient and appreciate the opportunity to service your *Release of Information* medical record request.

As you may know, we are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patients' rights to confidentiality as well as to track and report each request.

Therefore, in order to fulfill your request, we must ask for an upfront fee. This fee will offset the cost associated with copying, tracking, and reporting processes surrounding your request. Please indicate on the Request Form what medical records are to be copied and sent to the intended recipient. Please attach this form to the formal Medical Record Request and Authorization. This document will not replace the request or authorization.

Please include a check in the amount of $25.00, payable to BACTES, or fill out the credit card information below and return this form to us for processing. We will process your request when payment has been received. Please do not pay with cash.

Type of Credit Card (Visa, MC, or AMEX):_____

Credit Card Number: _____ Security Code: _____

Expiration Date: _____

Name on Card: _____

Billing Address: _____

_____

Telephone: (_____) _____

Requestor Signature: _____