

COTTINGHAM FAMILY DENISTRY

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Patient Records Request FROM Cottingham Family Dentistry

Name of Patient Whose Record is Requested _____

DOB _____ Phone _____

Address _____ City/State/Zip _____

Please provide a copy of the record as indicated below:

- The full health record maintained by this provider/practice
- The health record for the following time frame:
_____ through _____
- A specific section of the health record as described below:

- A summary of the information requested above is adequate to fulfill this request.
- As permitted by federal and state law, I understand that a fee of \$.65 per page will be charged for copying the records along with a clerical fee of \$6.00 per hour. In addition, a fee of \$12 will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive the copy of the record.

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____