Donald C. Sheridan, M.D.
10213 N. 92nd Street, Suite 101
Scottsdale, AZ 85258
Phone: (480) 860-6005 Fax: (480) 860-1882

Patient Name:_____ DOB:_____

Medical Records Request Fee

The office of Donald C. Sheridan, M.D., P.C., will provide your records to you once you have completed the Patient Authorization for Use / Disclosure of Protected Health Information (PHI) form. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

Your request will be processed and fulfilled within 30 working days. We will either mail or fax the records to the information you provide on the authorization form.

Listed below are charges for copying medical records:

Pages 1-20	$15.00
Pages 21-50	$25.00
Pages 51+	$40.00
X-Rays on CD	$10.00
X-Rays on paper	$1.00 per page

Form and Letter Fee

This is to notify you that the office of Donald C. Sheridan, M.D., P.C., will apply a fee of $20.00 to your account for patient, companies, family members, insurance carriers or other person requesting form and/or letters to be completed.

Forms include, but not limited to FMLA, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agents, gyms, etc.

In order to comply with federal laws including HIPAA as well as Arizona state and federal statues, this office must have a signed authorization from the patient / responsible party stating who we are authorized to release information to. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

_____ _____

Signature of patient or responsible party Date

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FORM AND LETTER FEE

This letter is to notify you, the patient, that a form completion fee of $20.00 will be applied to your account for patient, companies, family members, insurance carriers or other person requesting form and / or letters to be completed. Pre-payment is required to complete the request.

Forms include, but are not limited to, FMLA, disability, continuation of pay, payment of car loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agents, etc.

In order to comply with state & federal laws and HIPAA guidelines, this office must have a signed authorization from the patient stating who we are authorized to release information to. Please complete the bottom portion and return this to the front office receptionist.

Patient Name: (please print)_____

Form / Letter to be completed:_____

Released To: Name_____

Address:_____

Phone:_____

Fax:_____

Patient Signature:_____ Date_____

Responsible party signature (if applicable)_____

FOR INNER OFFICE USE ONLY

Date received:_____ Date completed:_____

Type of form:_____ Pt notified of fee: ____Yes ____No Employee Initials:_____

Billing department notified: ____ Yes ____ No Date paid:_____