Medical Records Request

Please complete the following records request and mail to:

USC Internal Medicine
Attn: Medical Records Department
1520 San Pablo St., Suite 1000
Los Angeles, Ca. 90033

Or

FAX TO (323) 442-5641

There will be a $15.00 flat fee if records are picked up.

There is **NO** fee if records are sent to another physician.

Records that will be mailed to the patient will be copied by
our in-house copy service:
HealthPort (800) 367-1500
Fee is .25¢ per page plus postage and tax

If you have any questions feel free to contact us at (323) 442-5100

UNIVERSITY OF SOUTHERN CALIFORNIA
ACCESS REQUEST FORM

Patient's Name: ____
Last First Middle

Date of Birth: ____

Phone Number: ____

I hereby request that my University of Southern California health care provider(s) provide me with the following information *(check all that apply)*:

☐ My clinical records (e.g., medical record, dental record)
☐ My x-rays
☐ My billing records
☐ Other ____
(*Must be personally identifiable information used by USC to make clinical decisions about the patient*)

Please check the boxes that apply:

☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period ________ through ___________.

☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by *(please list the name of your health care provider(s) whose records you wish to access)*:

____

____

☐ I agree to receive the Requested Information in the form of a summary prepared by USC at a cost to me of $____.

Information Excepted from Request
I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law. If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law (for example, a minor's receipt of contraception and/or family planning services).

Process if Request Denied

I understand that USC may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the USC who did not participate in the initial decision to deny my request.

I understand that USC will notify me of its decision to approve or deny my request to inspect the Requested Information within five (5) working days of receiving this request and within fifteen (15) days after receiving this request if my request is for copies, unless I agree to additional time to respond. USC will provide me with a summary of the Requested Information within ten (10) working days of receiving my request, or within a maximum of thirty (30) days if USC notifies me that more time is necessary, either because of the length of the record or because I was discharged from the hospital within the ten (10) day period to produce the summary.

Format for Providing Information

I would prefer to:

☐ pick-up or view the Requested Information at a mutually agreeable time and place; **OR**

☐ have the Requested Information mailed to me at the following address; **OR**

____
____
____

☐ have the Requested Information mailed to __________________ at the following address:

____
____
____

I understand that USC will charge me **[$_____]** per page for the copying services necessary to complete my request, as well as any applicable mailing fees.

____ ____________________
Signature of Patient (or Personal Representative) Date

____ ____________________
Printed name of Patient or Personal Representative Date

____
Relationship of Personal Representative to Patient