REQUEST FOR RELEASE OF ORIGINAL MEDICAL RECORDS

Instructions.

1. Complete this form in its entirety. A separate form must be completed for each patient's record requested. Please photocopy this form, if necessary.
2. Enclose $15.00 retrieval/release fee, plus $6.50 if records are to be shipped. ***Your request cannot be processed without advance payment.***
3. Payment methods: Credit Card, Personal Check, Cashier's Check, or Money Order (NO CASH, PLEASE) Payable to: **Iron Mountain**
4. Mail completed form and payment to:
   IRON MOUNTAIN / KPC, 1340 E. 6th Street, Los Angeles, CA 90021

I hereby request **IRON MOUNTAIN**, on behalf of **Chaudhuri Medical Corporation (KPC),** to release to me my original medical records. I understand that I am taking possession of the original medical records and that no copies will be retained. I acknowledge that Chaudhuri Medical Corporation strongly recommends that I provide medical records in their entirety to my current physician, as they may be needed for appropriate continuing care. I hereby release Iron Mountain and Chaudhuri Medical Corporation from any and all liability arising from release of my medical records to me and for any and all uses and disclosures of my medical records and any related information.

Amount enclosed or to be charged: $_____ ($15 record retrieval only; $21.50 retrieval and shipping)

Payment Method: (Check one)

☐ Credit Card - Circle One VISA / MasterCard / American Express Credit Card Number: _____

Expiration Date: _____ Name (exactly as it appears on card): _____

Signature of Cardholder: X _____

☐ Personal Check ☐ Cashier's Check ☐ Money Order (PLEASE DO NOT ENCLOSE CASH)

Retrieval Method: (Check one)

☐ I would like to pick up the records. (Once records have been located, you will be contacted at the telephone number listed below to make arrangements for you to pick them up in Cerritos, California.)

☐ I would like records shipped to me at the address listed below. I have included an additional $6.50 for shipment, for a total of $21.50.

DAYTIME TELEPHONE NUMBER AND ADDRESS:

_____
Name

_____
Street Address

_____
City, State, Zip

(_____)_____
Area Code and Telephone Number

Patient/Records Request Information:

Today's Date: _____ ☐ Medical Records Only ☐ Medical Records AND X-rays

Patient's Name (*Print*): _____ Patient's Date of Birth: _____

Other Name(s) Under Which Patient May be Listed: _____

Last Date of Service (Approximate): _____ Patient's Social Security #: _____

Former Medical Group and Location: _____

Patient, Parent or Legal Representative's Signature: X _____

If Legal, Representative: Print Name: _____ Relationship: _____

Briefly state why the patient cannot sign:

Patients who are minors between 12 and 18 years of age must sign this release in addition to parent/guardian.

Minor's Signature: X _____ Age:_____

For additional information, please call (213) 891-4143