Thomas C. Degenhardt, M.D.
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PROCESS FOR REQUESTING RECORDS

- Fill out medical Records Form correctly and entirely.
    - An invalid release/incomplete form will delay the process.
- Show ID
- We legally have 15 Business days to complete your request.
    - Monday – Friday 8am – 5 pm

(Begins once medical record department receives the request and form is completed correctly)

- Make sure to sign, date and check all confidential boxes.
- If you are requesting records for yourself, there is a fee of $15, no charge if sent directly to another medical provider/subpoenaed requestor.
- $15 Charge for all Medical Records and .25 per page after 50 pages when mailing paper records.
- There is a fee of $15 for Imaging on CD (per Disc)

If you have any questions, please call Medical Records Department at:

707-546-1922 Ext 5452

Or Email: Legal@srortho.com

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Medical Records Request Form

****Please Fill out All Stared Fields ****

*Patient Name:	*DOB:

★ ○ My Complete Records (last 7 Years) - $15 Charge and .25 per page after 50 pages when mailing paper records.

○ Only Records from (Date): _____ to (Date): _____

Comments or Specific Request:

_____

_____

(Paper Copy- $15 fee for personal records, no charge if sent to outside Medical Provider/Subpoenaed Request)

I hear by authorize _____ to release my confidential medical information and records to the physician, person, facility listed below. Information and records regarding treatment of minor, HIV, psychiatric mental health conditions or alcohol substance abuse have special rules that apply and require specific authorization.

- ***Yes___ No___*** *I authorize to release any and all records regarding drug, alcohol, or mental health treatment to the person(s) listed below.*

****Please Select Method of Delivery: ****

○ Pick Up _____

Phone Number: _____

○ Fax To: _____

Fax Number: _____

○ Mail to: _____

Address: _____

City/State/Zip code: _____

Permission for further use or disclosure of this medical information is not granted unless another is obtained from me or unless such disclosure is specifically required or permitted by law. A Photocopy or facsimile of this authorization shall be considered as an effective and valid original document.

*Patient Signature: _____ Date: _____

This form expires 1 Year After Signed

Front Desk Use Only

Paid: Yes: _____ No: _____ ID Verified By: _____

Please Fax this Form to 707-546-1897

Email to legal@srortho.com