REQUEST FOR TRANSFER OF HEALTH INFORMATION

Orthopedic & Physical Medicine Associates
71511 HWY 111 Suite A Rancho Mirage, CA 92270

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Policy without your authorization and completion of this form. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby request the transfer of health information for:

(Patient Name & Address:

_____
_____
_____

RECORDS TO BE TRANSFERRED:
I would like the following transferred:
[ ] All the records or [ ] The portion of the records concerning: _____

(Specify type of disease, accident, dates of treatment, or other portion of records.)

PLEASE TRANSFER THESE RECORDS TO: _____

(Name & address of health care provider to whom the records are to be delivered.)

CHARGES: I understand that you may charge me a [reasonable charge of up to $0.25 per page or $0.50 per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available***** I further understand that you may charge me your reasonable actual costs for providing copies of any X-rays or tracings derived from E.K.G., E.E.G. or E.M.G., or impose a reasonable deposit fee as a condition of their transfer.]

[ ] I hereby agree to pay the charges specified above. Please bill me.
[ ] Please call me to let me know how much these copies will cost.

Signed:_____Date: _____

Print Name:_____Telephone: _____

If not signed by the patient, please indicate relationship:
[ ] parent or guardian of minor paSent
[ ] guardian or conservator of an incompetent paSent
[ ] beneficiary or personal representative of deceased paSent