ARIZONA CENTER FOR
Hand to Shoulder Surgery

Hand to Shoulder Surgery & Reconstructive Microsurgery • www.achssurgeons.com

Request To Obtain Medical Records

Photographs/Radiographs

PATIENT NAME:_____ DOB: _____ Account #:_____

Date of Request: _____ Contact Phone #: _____ Treating Physician: _____

I request to have any Photographic and/or Radiographic images included in my Medical Records to be copied and released to me as indicated below.

The Following Information is Requested (check all that apply):

Radiographs (x-rays)
- ❑ Black & White Prints (no charge)
- ❑ E-Mail File ($10.00)
- ❑ CD/DVD ($15.00)

Photographs
- ❑ Black & White Prints (no charge)
- ❑ Color Prints ($15.00
- ❑ E-Mail File ($10.00)
- ❑ CD/DVD ($15.00)

CT Scan
- ❑ CD/DVD ($15.00)

A fee will be assessed for the completion of **EACH** Photographic/Radiographic request made.
Please note that it may take 7-10 business days from the date of the request to complete the request. Payment is due before any records will be distributed as requested.

Method of Delivery

- ❑ PATIENT /GUARDIAN PICK UP
- ❑ PATIENT REPRESENTATIVE TO PICK UP – Name of Individual: _____
- ❑ E-MAIL RECORDS TO : _____
- ❑ MAIL PRINTS /CD TO:

Name: _____

Address: _____

_____

Phone: _____

AUTHORIZATION

By signing below I am taking responsibility for the information/images released and acknowledge that once this information leaves the offices of ACHS, it is no longer covered by the HIPAA Security or Privacy Rules.

_____ _____
Patient Signature Date

_____ _____
Office Witness Date

Records Picked Up/Sent On:_____ Request Completed By: _____ Fee Collected On: _____