MEDICAL RECORD COPY REQUEST

PARENT/GUARDIAN

Date: _____

I, _____, am the parent/guardian
(Print Name Here)
of _____. I request a copy of his/her medical record from Giant Leaps Occupational Therapy, PC. I understand that I will be charged 10 cents per page and will receive the copy within 10 working days of the clinic's receipt of this request. Payment must be made in cash and is due upon the receipt of copies of records. If the copies need to be mailed, payment must be received by money order prior to the expedition of this request.

Signature:_____

Date Received by Giant Leaps Occupational Therapy, PC: _____
Appointment Date and Time to Receive Record: _____

MEDICAL RECORD COPY REQUEST

PATIENT

Date: _____

I, _____, request a copy of my
(Print Name Here)
medical record from Giant Leaps Occupational Therapy, PC. I understand that I will be charged 10 cents per page and will receive the copy within 10 working days of the clinic's receipt of this request. Payment must be made in cash and is due upon the receipt of copies of records. If the copies need to be mailed, payment must be received by money order prior to the expedition of this request.

Signature:_____

Date Received by Giant Leaps Occupational Therapy, PC: _____
Appointment Date and Time to Receive Record: _____