The Advanced Spine Center
Medical Records Request & Payment Form

Services provided by **Med Request Solutions Inc**. 800-483-6040

Patient Information

Patient Name: _____ Patient Signature: _____

Address: _____ Day Phone: _____ Date of Birth: _____

City/State/Zip:_____ (please confirm that all patient information is correct)

********I understand that there is a fee as outlined below: ********
Charges are as follows: $1.00 per page to a maximum of $50. Less than 10 pages will be provided at no charge

If you would like a copy of your medical records, please read carefully and fill out all sections below. Failure to fill out all sections will delay your request. Allow up to 30 business days for processing. **One Form per patient please.**

Information To Be Disclosed

Specify information and dates to be released:_____
_____

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), sexually transmitted diseases, hepatitis C, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL DO NOT RELEASE: _____

Signature of patient/guardian/authorized representative: _____ Date_____

___ please mail record to: Name: _____

Street: _____

City:_____ State:_____ Zip:_____ Phone:_____

Select Payment Method

___ I would like to be billed in advance: I understand that my chart will be copied and I will be billed in advance for the balance. Records will be mailed upon receipt of payment for the balance.

___ I would like to expedite this process and pay by credit card. Please bill these charges to my credit card. I understand that the charge will not be specified until all work is completed and that it will not exceed $50.00.

VISA _____ MASTER CARD_____ AMERICAN EXPRESS_____ DISCOVER_____
Cardholder Name: _____ Credit Card #:_____
Cardholder Signature:_____ Exp. Date:_____ Security Code:_____
Billing Address:_____ City:_____ State:____ Zip:_____

To avoid delay, complete all portions of this form. Mail or Fax to your physician's office:

The Advanced Spine Center
Attn: Medical Records Dept.
P.O. Box 2266
Morristown, NJ 07962

Fax (973) 538-0909