

**Northland Cardiology/Meritas Health Corporation
Patient Records Request Form**

Printed Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I am a patient of Meritas Health Corporation d/b/a Northland Cardiology (the "Provider"). I hereby request to:

- Review my medical records at the Provider's facility, or
- Obtain a copy of my medical records that are held by the Provider. Please select what records you would like to receive:
 - I would like to receive a copy of my entire medical record from _____ (date) through _____ (date).
 - I would like to receive the following information from my medical record:

(describe information, including dates and types of tests or conditions).

I understand that the Provider has thirty (30) days to act on my request. I understand that the Provider may deny my request, and if my request is denied that I may request review of the denial.

If I am requesting a copy of my medical records, I understand that I will be charged the current per page fee specified by the Missouri Department of Health and Senior Services for records that may be photocopied on a standard photocopy machine, plus the actual costs of duplication for any records held in other media, such as xray films, digital images, etc. If I elect to have my records mailed to me, I also will be charged an amount equal to the Provider's postage expense.

Please select a delivery method from the following:

- I would like my records mailed to me at the following address: _____
- I would like to pick up my records at the Provider's facility
- I would like my records faxed to me at: _____

Patient's Signature

Date

If someone other than the Patient signs this Request:

Printed Name: _____

Relationship to Patient:

_____ Legal Guardian

_____ Parent

_____ Other: _____ (please specify)