



HealthMatters Chiropractic

HIPAA Compliant Request for Records

Auditing of records for fidelity and completeness will be performed in order to ensure your records are complete. Please allow for time for such auditing to occur-same day record requests are typically not possible.

Patient Information:

1

Name of Patient _____

Date of Birth _____

Phone# _____

I am requesting that my records be sent to

HealthMatters Chiropractic

From : (name -department -phone etc.) _____

Type of records being sent

Clinical notes" _____

Lab Work _____

Xrays (please copies of reports and xrays)

Billing records _____

Date Range of Records _____

Reason for Request For Continuation of care

Time Frame As Soon As Possible Urgent

Send records to

HealthMatters Chiropractic

6825 Stewart Rd. Galveston, TX 77551

Or fax to (409) 744-2253

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I am requesting that my records be sent

from HealthMatters Chiropractic to...

(incomplete information may delay record processing)

Type of records being sent

Clinical notes" _____

Lab Work _____

Xrays : copies of reports or CD of xrays

Billing records _____

Date Range of Records _____

Time Frame

As Soon As Possible

Urgent : Please process by : _____

Note : Records request are not available on a same day basis. Expedited records requests may involve fees. Please discuss any special requirements.

Within the limitations of Law, every effort will be made to accommodate your request. You will be contacted if Fees apply to the production of your records. **There is a \$10 fee for Xray CD production. There is a minimum \$10 fee for mailing of records.** This request will be specifically for the indicated records for this event. Should you require a generic (open) request for ongoing billing or record needs, please consult the staff. You will be notified of any denial to produce, whole or in part, records for this request. Please note that we may be prohibited from making changes to, or disclosing, certain information available, including psychotherapy notes, or information from legal proceedings, medical research, or where state or federal laws prohibit the disclosure, where such disclosure may result in harm or injury to another person, or information obtained under a promise of confidentiality.

Estimated Fee

Xray _____
 Postage _____
 Copying _____
Payments _____
 Actual Fee \$ _____
 Balance _____

3

PRINT

Name of signatory (Patient or guardian + relationship) _____ date _____ Signature _____

Received by _____ Processed on _____ by _____