## Medical Records Request

Please complete the following records request and mail to:

USC Internal Medicine Attn: Medical Records Department 1520 San Pablo St., Suite 1000 Los Angeles, Ca. 90033

Or

FAX TO (323) 442-5641

There will be a \$15.00 flat fee if records are picked up.

There is **NO** fee if records are sent to another physician.

Records that will be mailed to the patient will be copied by our in-house copy service:

HealthPort (800) 367-1500

Fee is .25¢ per page plus postage and tax

If you have any questions feel free to contact us at (323) 442-5100

## UNIVERSITY OF SOUTHERN CALIFORNIA ACCESS REQUEST FORM

Patient	's Name:			
Date o	f Birth:	Last	First	Middle
Phone	Number:			
	• •	my University on ation (check all a	of Southern California health care protected that apply):	ovider(s) provide me with
	My clinical re	ecords (e.g., med	dical record, dental record)	
	My x-rays			
	My billing re	cords		
	`		ntifiable information used by USC i	to make clinical decisions
Please	check the box	xes that apply:		
	•		ssing or obtaining a copy of Request ough	ted Information relating to
			or obtaining a copy of all Requested in the contract of the co	
□ cost to	I agree to recome of \$	eive the Request	ted Information in the form of a sumr	nary prepared by USC at a

## <u>Information Excepted from Request</u>

I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law. If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law (for example, a minor's receipt of contraception and/or family planning services).

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## Process if Request Denied

I understand that USC may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the USC who did not participate in the initial decision to deny my request.

I understand that USC will notify me of its decision to approve or deny my request to inspect the Requested Information within five (5) working days of receiving this request and within fifteen (15) days after receiving this request if my request is for copies, unless I agree to additional time to respond. USC will provide me with a summary of the Requested Information within ten (10) working days of receiving my request, or within a maximum of thirty (30) days if USC notifies me that more time is necessary, either because of the length of the record or because I was discharged from the hospital within the ten (10) day period to produce the summary.

Format for Providing Information I would prefer to:	
pick-up or view the Requested Information at a mutually a	greeable time and place: <b>OR</b>
have the Requested Information mailed to me at the follow	
have the Requested Information mailed to	at the following address:
I understand that USC will charge me [\$] per page for the complete my request, as well as any applicable mailing fees.	ne copying services necessary to
Signature of Patient (or Personal Representative)	Date
Printed name of Patient or Personal Representative	Date
Relationship of Personal Representative to Patient	

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