Care Station MEDICAL GROUP

MEDICAL RECORDS REQUEST FORM

Form may be downloaded from
www.carestationmedical.com

To avoid delay please complete ALL portions of this form and submit by:
Fax: (908) 540 – 0477
E-mail: medrecords@carestationmedical.com
Mail: Care Station Medical Group
328 West St. Georges, Linden, NJ 07036
Or return this form to your physician's office.

Any Questions: Please call (908) 925-2273

A: PATIENT INFORMATION

Name: _____ ___ _____ DOB: ___/___/___
First MI Last M / D / Y

Patient Signature: _____ **(If Requestor is someone other than Patient, please complete Section B below)**

Street: _____
City: _____
State: _____ Zip: _____ Country: _____ (If not U.S.)

Home Tel: ( ) ---
Mobile Tel: ( ) ---

B: REQUESTOR INFORMATION (Only If Other Than Patient – Proof Of Authorization/Guardianship Required)

Name: _____ ___ _____ Relationship to Patient: _____
First MI Last

Street: _____
City: _____
State: _____ Zip: _____ Country: _____ (If not U.S.)

Home Tel: ( ) ---
Mobile Tel: ( ) ---

I understand that there is a fee as follows: $ 0.32 per page plus postage for all pages provided (up to a maximum of $100). There will be a separate, additional fee of $25 per CD for x-ray images, if requested. For 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. Please allow up to 30 business days for processing. One form per patient please.

Requestor's Signature: _____ Date: _____

C: INFORMATION TO BE DISCLOSED

Specify information and dates of service to be released: _____

I understand that my health records 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 : _____

Please send records to:

ADDRESS: ☐ **Same as that of Patient**

Name _____
Street: _____
City: _____
State: _____ Zip: _____

Tel: ( ) ---
Fax: ( ) ---
E-mail: _____

D: 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 amount due. Records will be mailed upon receipt of payment for the amount due.

☐ I would like to expedite this process and pay by credit card. Please bill these charges to my credit card.

☐ VISA ☐ MasterCard ☐ DISCOVER CC #: _____ Exp: _____ Sec Code: _____

Cardholder Name: _____

Billing Address: _____ State: _____ Zip: _____

Cardholder Signature: _____

Service provided by Med Request Solutions Inc. Phone 1-800-483-6040 Ext. 2

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