PATIENT RECORD REQUEST

Patient Name_____ I.D.#_____ DOB:_____
(print)

I _____hereby request the following:
Patient and/or Patient Representative

____ To view my record

____ To receive a paper copy of my record

____ To receive an electronic version of my record in the form and format indicated here:

_____

Requests must be submitted in writing to Foot Health Center, LLC (Office of Dr. Michael Verdi, Dr. Douglas DeLorenzo, Dr. Merihan Botros, Dr. Kirsten Discepola and Dr. Patricia Berran. If approved, an agreed upon date, time and place will be scheduled. If the electronic form and format requested is not readily producible by Foot Health Center, LLC in such form and format requested, then Foot Health Center, LLC will provide a readable electronic form and format as agreed. A nominal fee may be charged for the labor of copying, whether in paper or electronic form, and supplies for creating a paper copy or electronic media if requested on portable media. If the request is denied, the patient and/or patient representative will be informed as to the reason why.

Date: _____

Time: _____

Place: _____

Received copy of record:_____
Signature of Patient and/or Patient Representative

Date: _____

Request received by:_____ Date: _____

Foot Health Center, LLC 1500 Pleasant Valley Way, Suite 204, West Orange,NJ 07052
973-731-1266/ Fax 973-731-1712