SUMMIT ORTHOPEDIC SPECIALISTS
Saving Lifestyles

Medical Record Requests

Please note: Certain requests may be subject to a fee. We will call and notify you of the cost, as payment is required before records are released.

To request the following records:

- Personal request for medical records
- Medical records for continuity of care
- Radiology records
- Complete and submit the Summit Orthopedic Specialists form attached:
    - Request for Patient Access to Health Information (PDF)

Note: When you have completed the steps above, fax all paperwork to (916)965-4813 or mail to Summit Orthopedic Specialists, 6403 Coyle Ave. #170, Carmichael, CA 95608. It may take up to 15 business days to process your request.

To check the status of your request, please contact our office at: (916)965-4000.

Request for Patient Access to Health Information

Summit Orthopedic Specialists
6403 Coyle Avenue, Suite 170, Carmichael, CA 95608
Phone: (916) 965-4000
Fax: (916) 965-4813

As required by the Health Information Portability and Accountability Act of 1996 and California law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider. By law Summit Orthopedic Specialists has fifteen (15) business days to supply copy of records. However, every effort will be made to provide copies as soon as possible.

I hereby request access to health information for:

_____

_____.

(Print Patient's name and address)

If known: Date of Birth:_____ Date of Request: _____

From Dr. (circle one) Sasaura Greene Cameto

Other (please list): _____

SCOPE OF ACCESS REQUESTED

I would like access to: ☐ All the records ***or***
☐ The portion of the records concerning:

_____

(Specify type of disease, accident, dates of treatment, or other portion of records you are interested in.)

Include records related to infectious disease, including HIV? Yes/No
Include records related to alcohol or drug abuse? Yes/No
Include records related to psychological or mental disorders? Yes/No

Reason for request: _____

TYPE OF ACCESS REQUESTED

☐ Inspection. Please let me know when I may come to inspect the records, and the amount of the charge, if any. I understand that an employee of this medical practice may be present and that I may not make any marks or alter the records in any way.

☐ Copies. I would like copies of ☐ All records requested ***or***
☐ All records other than X-rays or tracings

☐ Transfer. Please transfer ☐ Copies of all records requested ***or***
☐ X-ray copies or tracings only

To: _____
(Name and address of health care provider to whom the records are to be delivered)

CHARGES

Copies or Transfer. I understand that I will be charged and responsible for applicable reasonable charges of twenty dollars ($20.00) for copies of my records and/or twenty dollars ($20.00) per copy of x-ray CD and/or twenty dollars ($20.00) per sheet for X-ray copies. Charts and/or x-rays two (2) years and older will have an additional charge of $20.00 for storage retrieval fees per chart.

- ☐ I hereby agree to pay the charge(s) specified above.

- ☐ Please call me to let me know how much these copies will cost.

I give permission to (name of person)_____ to pick up my records.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____