REQUEST TO GET MEDICAL RECORD

*Note- Each adult that wants to get their record should fill one of these forms. (ie a couple needs to fill two forms, one for each partner)

Date:_____

Name of Patient :_____

Date of Birth of Patient:_____

Dear Umedical, Please provide a complete record of medical records for :

-Myself (provide name) : _____

AND/OR

-My Next of Kin Under 18 years for whom I am guardian (provide name/s)

_____

_____

-I agree to pick up my record IN PERSON and provide personal identification prior to release of my record(s).

-I will pick up the record that will be in the form of a USB key, at Umedical between office hours of Monday-Friday 9-12 pm and 1 to 5 pm

-I agree to pay an administrative fee for each record requested - First 20 pages $30 (Each page after 20 : $0.25). This payment will be made prior to the creation of the copy of my record and I agree
to be invoiced by electronic means.

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Signature of Patient Requesting Record(s)