15215 Shady Grove Rd. Suite 100, Rockville, MD 20850
(301) 519-0902-Tel
(301) 519-0905-Fax

Transfer Records / Copy of Records Form

PATIENT'S NAME	*DATE OF BIRTH*

Person Making Request: _____ Phone Number: _____

Address: _____
(Street) (City) (State) (Zip code)

Phone Number: _____ Reason for Request: _____

There is a charge of $.76 per page. If mailed, postage will be an additional charge. Payment must be made before any copies are picked up/mailed out. For your convenience we accept Cash, Discover, Master Card and Visa.

How would you like your records delivered:

□ **Fax** Attention to: _____
Fax Number: _____

□ **Mail** Attention to: _____
Address: _____
_____

□ **Email-** email address: _____

Please note if you choose your medical records to be emailed at the above email, you understand your information is not 100% safe/protected, per HIPAA guidelines. Our email is not encrypted, therefore your information is not fully protected. By choosing your medical records to be emailed, Physicians Now, LLC will not assume responsibility nor liability for any information that is exposed. Physicians Now, LLC strongly recommends to stay within the HIPAA guidelines. Which is by picking up, faxing or mailing medical records.

I agree and understand the above email disclaimer. By signing this I will not hold Physicians Now, LLC responsible for any HIPAA violations.

Patient Signature: _____

Copy of Records Charge _____
Previous Balance _____
Total Due _____
Total Received _____

□ Notified of transfer of record's fee and any previous outstanding balance.
Spoke to_____
Date_____
Initial _____

□ Picked up: _____
_____
(Signature of person picking up)

Patient or Guardian Signature: _____ Date: _____

Patient Name: _____ Relation to Patient: _____