Signature HEALTH

MEDICAL RECORDS REQUEST & FEES

Date of request: _____/_____/__________

Client name: ____

Client DOB: _____/_____/__________

Client phone number: (______)___________________________

Location where you received services (*check all that apply*):

- ☐ **Signature Health**
- ☐ **Connections**
- ☐ **Family Planning**
- ☐ **ORCA House**

Reason for records: ____

Dates of service: ____

*****Release MUST be signed*****

Send records to: ____

Fax number: (______)______________________ Phone number: (______)___________________________

I have requested records for the above client and agree to pay any charges that accompany this request.

Sign Here: ____________________________________ ____

Signature of Client/Client's Legal Representative *Relationship to Client*

Persons requesting records will be charged the following copying and postage fees. No fees are charged when a client or client's personal representative requests records to support Social Security Disability claims. **Fees payable upon delivery/pick up.**

Copying fees

Pages:	Fees:
1-10	$2.75 per page
11-50	$0.57 per page
51 *or more…*	$0.23 per page
Postage	*Standard first class postage rate*

Your total: $________________________________

*****Return this form to the Medical Records Department*****

Fax 440-269-2551

Signature Health Inc. -- 38882 Mentor Ave., Willoughby, Ohio 44094