



Summergeate Professional Center
27406 Cashford Circle
Wesley Chapel, FL 33544
Phone (813) 994-8900
Fax (855) 388-5350

Medical Records Request Form

Date of request _____

I, _____, request Scotch Institute to make copies of my medical records for my personal inspection. I understand that these records contain protected health information. I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be \$1.00 per page for the first 25 pages of written material and \$0.25 for each additional page. I agree to pay for this prior to the service being rendered.

Patient Printed Name _____

Date of Birth _____

Please specify if you want to pick them up at our office or if you would like us to mail them to you. If mailing, please note the address below, or if picking up please advise a phone number where we can reach you when the copies are ready.

Patient Signature _____