



Northeast Orthopedics, Inc.

Orthopedic Surgery and Sports Medicine

164 Wetherby Lane, Westerville, Ohio, 43081 ph: (614) 839-2300 fax: (614) 839-2301

MEDICAL RECORDS POLICY

Patient Name: _____ DOB: _____

Person Requesting Info: _____ Phone # : _____

Address: _____
_____ Fax # : _____

We recently received a request for a dictated letter and/or copy of medical records for the above patient. Our fees are as follows:

Dictated Letter of Medical Record (Attending Physician Statement)	Brief:	1-2 office visits	\$250.00
	Moderate:	3-4 office visits	\$375.00
	Extensive:	5+ office visits	\$500.00

Copy of Medical Records	Pages 1-10:	\$2.59 per page
	Pages 11-50:	\$0.53 per page
	Pages 51+ :	\$0.21 per page

Record Retrieval Fee There is a retrieval fee of \$15.87

TOTAL: _____

Please note that your request will be released upon receipt of payment. Checks may be made payable to Northeast Orthopedics, Inc.

If you have questions, please do not hesitate to call the office. Thank you in advance for your time and cooperation.

Sincerely,
The Physicians and Staff at Northeast Orthopedics

For Office Use Only

Information Requested: _____	Release Signed <input type="checkbox"/>
Request for Payment Sent Date: _____	Method: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> In Person Initials: _____
Payment Received Date: _____	Method: _____ Amount: _____ Initials: _____
Letter Dictated Date: _____	Initials: _____
Request Sent Date: _____	Method: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> In Person Initials: _____