Fredericksburg Orthopaedic Associates, PC
Ciox Health 1.800.367.1500 / Fax 540.310.0100
MEDICAL RECORD AND X-RAY REQUEST PLEASE PRINT ALL INFORMATION

Date _____/_____/_____
(mm / dd / yyyy)
Patient: _____

Patient's Address: _____

City _____ State _____ Zip Code_____

Patient's Date of Birth: _____/ _____/_____ Patient's SS #: _____ - _____ - _____
(mm / dd / yyyy)

Medical records and/or x-rays are being requested on the above named patient. The patient and or the patient's guarantor are responsible for the cost of each set of reproduced medical records and or x-rays. All copies requested and processed, will be charged to your account. The reproduction fee is:

- Mail Delivery: $0.90 base fee plus $0.05 Per page for each
- E-mail Delivery: $6.50 Total
- Mail Delivery: $5.00 Each X-ray CD

The cost of postage to mail medical records is charged to the patient/guarantor. **Please see the option below to receive medical records electronically.** If the patient requests medical records to be sent to a third party, the patient will be responsible for the cost of the medical records.

We require a minimum of 15 days to process your request.

Reason for Request:

o Patient Use o Attorney o Insurance (including compensation or disability)

o Other Physician requested o Other_____

Send Records to:_____

Address:_____

Phone:_____

This request is for: (check below)

o CD- X-ray only o All x-rays o Only those notated below

_____

Medical Records Only:

o All Medical Records o Only those records notated below

_____

Ciox Health processes all medical records requests. **To receive your records as an electronic PDF file via email; please request and complete the Electronic Record Delivery Request form along with a HIPAA Authorization.** Otherwise, the requested medical records will be mailed to the stated address on this form. You may contact Ciox-HealthPort to inquire about your request at 1.800.367.1500 or www.cioxhealth.com.

Siganture Patient's/Legal guarantor

X_____(Contact Phone#)_____

FOA Initials _____