

# Medical Records Request

Please complete the following records request and mail to:

**USC Internal Medicine  
Attn: Medical Records Department  
1520 San Pablo St., Suite 1000  
Los Angeles, Ca. 90033**

Or

**FAX TO (323) 442-5641**

There will be a \$15.00 flat fee if records are picked up.

There is **NO** fee if records are sent to another physician.

Records that will be mailed to the patient will be copied by  
our in-house copy service:

HealthPort (800) 367-1500

Fee is .25¢ per page plus postage and tax

If you have any questions feel free to contact us at (323) 442-5100



Process if Request Denied

I understand that USC may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the USC who did not participate in the initial decision to deny my request.

I understand that USC will notify me of its decision to approve or deny my request to inspect the Requested Information within five (5) working days of receiving this request and within fifteen (15) days after receiving this request if my request is for copies, unless I agree to additional time to respond. USC will provide me with a summary of the Requested Information within ten (10) working days of receiving my request, or within a maximum of thirty (30) days if USC notifies me that more time is necessary, either because of the length of the record or because I was discharged from the hospital within the ten (10) day period to produce the summary.

Format for Providing Information

I would prefer to:

pick-up or view the Requested Information at a mutually agreeable time and place; **OR**

have the Requested Information mailed to me at the following address; **OR**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

have the Requested Information mailed to \_\_\_\_\_ at the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that USC will charge me [ \$\_\_\_\_\_ ] per page for the copying services necessary to complete my request, as well as any applicable mailing fees.

\_\_\_\_\_  
Signature of Patient (or Personal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Personal Representative to Patient