Medical Records Request Form

Client's Name: _____Client's DOB: __ __ / __ __ / __ __

Date(s) Requested: _____
Name of Provider(s): _____

Requested by: Client ☐ Other ☐ _____
Name of Person Requesting Records: _____
Phone Number: _____
Type of Records Requested: _____

Requested Delivery Method:

Mail ☐ Address: _____
Fax ☐ Number: _____
Pick up ☐ Requested Date: _____

Please note:
All fees must be paid in full prior to our office sending out any medical records:

Retrieval Fee: up to $23.13
First 25 pages: $1.17 per page
Pages 26-50: $0.88 per page
Pages 51-100: $0.57 per pages
Pages 101+: $0.35 per page

Client signature (state relationship if parents, guardian or legal representative):

_____

Date: _____

I understand that ABA of Wisconsin will provide the requested records within 15 days from receipt of the written request and that a cost-based fee will be charged for copying my medical record. The fee includes the cost of supplies and the labor for making copies. A postage fee will be applied for all records that are requested by mail.