

Dear Patient or Patient Representative:

The UC San Diego Health System Health Information Services department has hired INTEGRITY Health Information Services to handle all its release of information requests. In accordance with CA Civil Code 123110 and HIPAA: 45 CFR 164.524, INTEGRITY Health Information Services has established the following fees for processing your request.

Please provide us with the following information:

PATIENT'S NAME: _____

MEDICAL RECORD #: _____

DATE OF BIRTH: _____

Initial and circle your selection below. You will be required to make payment upon receipt or request of records. Please be advised that INTEGRITY Health Information Services accepts checks, VISA and MASTERCARD.

FEE Schedule:

_____ **Routine:** Required in 15 days: \$0.25 per page + postage
(Please note: sales tax and applicable postage will be added to total fee.)

(Signature of patient or representative)

Date: _____

(Print Name)

Telephone: (____) _____

Relationship to patient (if other than patient): _____

<p><u>For credit card billing:</u> <input type="checkbox"/> VISA <input type="checkbox"/> M/C</p> <p>Credit card #: _____ Expiration Date: _____</p> <p>Name on credit card: _____</p> <p>Credit card billing address: _____</p> <p>_____</p>
