Katherine E. Chou, DPM

2186 Geary Blvd., Suite 312, San Francisco, CA 94115
Phone: (415) 426-7771 Fax: (415) 967-7053
admin@drkatherinechou.com

REQUEST FOR MEDICAL RECORDS

I, _____ request a copy of my full medical records from Katherine Chou, DPM.

By signing below I acknowledge and agree that my records will be released to me on a CD.

Dr. Chou's office has up to 30 days to fulfill this request.

There is a $25.00 administrative fee for the records. All fees to be paid at time of request.

☐ I will pick up the CD of my medical records PERSONALLY from the office, or provide written authorization to allow a specific named individual to pick them up for me.

☐ I want the CD of my medial records mailed to me at the following address. I agree to pay and additional fee of $10.00 for shipping and handling via Fed-Ex. (Medical records will not be sent by US mail for security reasons.)

Address to send records: _____

_____

_____

_____

Patient's signature Date