

Last Name	First Name	M.I.	TRS # (office use)
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Request to Release Medical Records for Personal Use

Tri Rivers Surgical Associates, Inc. (The "Practice")

The Practice will permit you to inspect and obtain a copy of most of your medical information maintained at the Practice. We may deny your request to inspect and copy in certain limited circumstances.

I understand that I will be responsible for a charge of \$_____ per page to obtain my records and that they will not be distributed until the invoice for said fee is paid in full.

I, _____, (Name of patient or patient's representative) hereby request to inspect and copy protected health information in my medical record, as described below.

Please provide a specific description of the type of information to be released, including dates. Be as specific as possible regarding what medical information you are requesting to have released.

Patient Date of Birth: _____ Phone Number: _____

Please indicate how you would like to receive the information:

- By mail at this address: _____
- Pick-up at the Practice office in:
 - North Hills
 - Cranberry/Mars
 - Butler – Clearview
 - Butler – BHS East
 - Slippery Rock
- By fax at this number: _____

 (Signature of patient or patient's representative)

 (Date)

 (Printed name of patient or patient's representative)

Completed forms may be sent to the fax number or mailing address below.	
Fax: (412) 630-8019 Attn. Forms & Medical Records Dept.	Mail: Tri Rivers Surgical Associates Attn. Forms & Medical Records Dept. 9104 Babcock Blvd., Suite 2120 Pittsburgh, PA 15237

Office Use Only:	<input type="checkbox"/> Records given to patient	<input type="checkbox"/> Scanned into Mobile MD
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