

## **REQUESTING COPIES OF YOUR MEDICAL RECORDS**

- It is a Federal law that the original patient record is the property of the medical entity. The patient may receive a photo copy of their medical record.
- State of New Jersey Department of Health regulation 8:43G-15.3 states that the patient will be charged \$1.00 per page for the first 100 pages of their record and then \$.25 per page up to a maximum charge of \$200.00 per record.
- There is no charge for sending records directly to a health care provider for continuation of care; provided the physician's complete mailing address, including a phone number is indicated on the authorization release form. If you want your records to be sent directly to your healthcare provider, please provide your health care provider's name, address, phone number, fax number and your date of appointment at the top of the authorization form.
- If you want your records to be mailed to someone other than your healthcare provider, you will be charged a fee for those records. Please provide the name of the recipient, address, and telephone number at the top of the authorization form. It can take up to 30 days for you to receive the records. After your request is processed, you will receive an invoice in the mail. Upon receipt of payment, the records will be mailed to the address indicated on the form.
- Our mailing address and contact information is listed below:

**Cooper University Healthcare  
Health Information Management  
1 Federal Street – Suite 200  
Camden, NJ 08103-1118**

### **When filling out the authorization, remember to:**

- PRINT all information clearly
- Include the specific admission(s) and service date(s) that you are requesting.
- Include the complete mailing address.
- Under "Description of Health Information Subject to this Authorization", it is important to check all of the boxes that relate to your treatment while a patient at Cooper.
- In order for the authorization to be valid, the form must be signed and dated.
- If you are a parent or guardian, please sign under "Authorized Representative" at the bottom right hand corner of the form.
- Provide the patient's name, address, phone number and date of birth at the bottom of the form.