



I would like the information in the following form or format if it is readily producible in this form: \_\_\_\_\_

## CHARGES

**Inspection.** I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of [\$6.00] per quarter hour and I may be required to pay these cost before I may inspect the records.

**Copies or Transfer.** I understand that you may charge me a reasonable charge of up to twenty-five cents (\$0.25) per page, or fifty cents (\$0.50) per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available. I further understand that you may charge me your actual costs for copies of any X-rays or tracings derived from electrocardiography (E.K.G.), electroencephalography (E.E.G.) or electromyography (E.M.G.).

- I hereby agree to pay the charges specified above. Please bill me.
- Please call me to let me know how much these copies will cost.
- I am requesting these records be provided without charge to appeal the denial of eligibility for Medi-Cal, SSDi or SSI/SSP benefits. A copy of the program's denial notice is attached. I applied for these benefits on \_\_\_\_\_ (date).

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_