CERTIFICATION OF MEDICAL RECORDS

Patient Name: _____

I certify that the documents attached to this certificate, consisting of _____ pages, are accurate and complete duplicates of the original medical records of the patient listed above for the following period of time:

_____ to _____

Exclusions: ☐ None

☐ As follows: _____

_____

_____

_____

_____

☐ **Certification of No Records**: A thorough search of our files, carried out under my direction, revealed no documents, records or other materials called for in the medical records request.

I further certify that the produced records are a true copy of ALL the records requested and are kept in the course of regularly conducted activity.

Executed on this _____ day of _____, _____

_____

Records Custodian (signature)

_____

Printed Name of Records Custodian

_____

Name of Facility or Practice (Please Print)