MEDICAL RECORDS DECLARATION

I, _____, an employee of_____
(Certifier's Printed Name) (Business Printed Name)

_____,
(Business Printed Address, City, State)

☐ am the Custodian of Records, or under the direction of the Custodian of Records,

☐ am a submitter on behalf of the Custodian of Records

for _____,
(Provider or Facility Printed Name)

_____, Texas,
(Provider or Facility Printed Address, City)

I make this declaration based on my personal knowledge of the facts stated herein.

☐ Attached hereto, immediately following this declaration are _____ **single-side printed** pages of medical records. I have counted only pages of actual medical records and not placed any other documents between this certification and the first page of medical records.

☐ Attached hereto are medical records in **CD-ROM read-only format,** with a CD creation date of _____, that were created from the original records, which (*check one:)* ( ) are not , *or* ( ) are password protected. If password protected, I understand that the actual password must be supplied prior to any submission deadlines.

The said records were kept by the above listed provider or facility in the regular course of business, and it was the regular course of business for any employee or representative of the above listed provider or facility with knowledge of the act, event, condition, opinion, or diagnosis recorded to make the records or to transmit information thereof to be included in such records; and the records were made at or near the time or reasonably soon thereafter. (If submitted on behalf of the Custodian of Records, these pages are exact copies of the records transmitted to the above listed business under the supervision of the Custodian of Records of the above listed provider or facility, who confirmed this as true.) The medical records attached here to are the original or exact duplicate of the original and no other documents exist on the file

for_____,
(Printed Patient Name)

also known as, _____,
(Printed Patient Alias Names, if applicable)

Medicaid recipient # :_____, related to **ICN:** _____
(PCN)

for the time period from _____ to _____.
(Actual Dates of Service, from Medical Records)

I declare under penalty of perjury that the foregoing is true and correct.

_____ Date:_____.
(Certifier's Signature)