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RELEASE OF MEDICAL RECORDS

Date of Request: _____/_____/_____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____

I hereby give permission to provide records to:

_____ Myself: I am the Patient or Legal Guardian

_____ 3rd Party

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

I am Requesting the following Records:

____Entire Medical Records

____ Biopsy/Pathology Reports

____ Lab Work

____Office Visits

____ Other

_____

_____

_____

Format and Fees:

All records will be charged at $0.50 per page up to the first 50 pages, and $.25 for each page that follows. All formats of records requests will be subject to the applicable postage and delivery fees and a $10 processing fee.

_____ Paper

_____ Electronic Options

_____ CD $6.50 in addition to the applicable page, postage, and processing fees

_____ Email: subject to all applicable page, postage and processing fees

Email Address: _____

☐ For **email communication,** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

_____ _____

Print name of Patient, Parent or Legal Guardian Date

_____ _____

Signature of Patient, Parent or Legal Guardian Date