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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:

_____ Paper $0.50 per page up to the first 50 pages, and $0.25 thereafter, in addition to applicable postage if mailed.

_____ Electronic:

_____ CD $6.50 flat rate

_____ Email: No Charge: Please read the disclosure below:

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