Name:

DOB: Age:

Chart: Date:

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____
Last First MI Maiden or other names

DATE OF BIRTH: _____ Medical Record # (if available): _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

DAY PHONE: _____ **EVENING PHONE:** _____

I hereby request to: (check only one)

_____ **have my medical records sent to the address at right**

_____ **receive a copy of my medical records**

NAME _____

ADDRESS _____

CITY _____ **ST** _____ **ZIP** _____

PHONE _____ **FAX** _____

INFORMATION TO BE RELEASED:

	DATES
☐ History and physical exam	_____
☐ Progress notes	_____
☐ Lab reports	_____
☐ X-ray reports	_____
☐ Other: _____	_____
_____	

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)

☐ Mental health (including psychotherapy notes)

☐ HIV related information (AIDS related testing)

X _____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Please note that we will only be responsible for the copying of x-ray reports and lab results as ordered by this office.
All other information will need to be obtained from the original facility or the ordering physician.

I understand that fees may be required to be paid in advance before records can be released or reviewed:

- Copying of medical records — $.65 per page plus postage if mailed
- X-rays loaned — No charge unless mailed
- X-rays copied — $35 per sheet
- X-rays mailed — $35 per sheet plus postage
- CD — $5

_____ _____ or _____ _____

SIGNATURE OF PATIENT **DATE** **PARENT/LEGAL GUARDIAN/AUTH. PERSON** **DATE**

_____

RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST RECEIVED _____ DATE REQUEST FILLED or DATE OF APPT TO INSPECT RECORDS _____

PATIENT NOTIFIED ON _____ BY _____

HOURS OR PAGES BILLED _____ X RATE OF $_____ + X-RAY FEES $_____ = $_____ COLLECTED $_____