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MEDICAL RECORD RELEASE REQUEST

Patient's Name: _____
Last First M

Date of Birth: _____ S.S.N:_____

Phone number: _____ Email Address (optional): _____

I authorize my medical records to be released to:

Recipient's Name: _____

Address: _____

Fax Number: _____ Email: _____

Check records to be released:

- ☐ All medical records
- ☐ Clinical Notes
- ☐ Test Results / Radiology Reports (MRI/XRAYS/LABS)

I understand and will pay the fee for obtaining medical records (if applicable):

- No charge to fax records or if less than 50 pages
- $30 for 50+ pages printed or $15 for CD of records
- We required 5 working days to complete the request, additional $10 fee if records need to be rushed.

****There may be a fee for the shipping and handling****

We do not store films of MRI or X-rays that were done at the other facilities. Please contact the facility directly.

_____ _____
PATIENT'S SIGNATURE **DATE**