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MEDICAL RECORD RELEASE REQUEST

To Dr. Anderson:

Please ☐ email, ☐ fax, or ☐ mail paper or CD (possible fee), a copy of my medical record to:

RECIPIENT'S NAME **FAX NUMBER/EMAIL**

MAILING ADDRESS

CITY **STATE** **ZIP**

Below is my personal information.

PATIENT'S FIRST NAME **PATIENT'S LAST NAME**

DATE OF BIRTH **SSN**

CONTACT NUMBER **EMAIL (OPTIONAL)**

_____ (Initial) I realize and understand that email/CD is not secure and my private health records could be seen by others. The office will password-protect the file using my Date of Birth as the password as a courtesy for my protection.

SINCERELY,

_____ _____
PATIENT'S SIGNATURE **DATE**

FEES FOR PATIENTS OBTAINING MEDICAL RECORDS

- One time no charge if less than 50 pages (ex. Op report/ MRI report only), each additional request is $30
- $20 if the chart is at an offsite storage facility – patient who had no appointment after 2004, no rush request
- $30 for 50+ pages mailed or $15 for CD
- 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.