PLEASE ALLOW 10-14 DAYS FOR RECORDS TO BE PROCESSED/COPIED

Date Received: _____
Employee's Initial: _____

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Medical Records Request/Release

Patient's Last Name: _____ First Name: _____ Middle Name: _____ Date of Birth: ____/____/_____

Social Security # _____ Home Telephone _____ Cell Phone_____

Address: _____City_____State_____Zip code_____

The records or information I wish to be sent or received are: (check all that apply)

☐ History ☐ Physical ☐ Progress Notes ☐ Lab reports ☐ EKG reports

☐ Other (please specify): _____

The reason I want these records or information transferred is:

☐ For medical care ☐To go to an attorney ☐ To go to my insurance company ☐ Other (please specify) _____

- This authorization is valid for a period of 120 days from the date of the signature below, and can be revoked/cancelled in writing at any time prior to the expiration date
- The patient agrees that a copy of this authorization may be considered valid: Yes_____ No_____
- Are you transferring your care to another physician? Yes_____ No_____
  If so, please explain why: _____

Patient's signature Authorizing Request/Release of Records:

Signature: _____ **Date:** _____

Physician's signature Authorizing Release/Request of Records:

Signature: _____ **Date:** _____

If records are being requested by the patient or being sent to any other facility other than a healthcare provider, there is a $25 charge for the 1st 20 pages of medical records and $0.15 for any page thereafter. There is no charge for records being sent to another healthcare provider.