

Authorization for the Release of Medical Records

Patient Name: _____

Date of Birth: ____/____/_____

Address: _____

Telephone Number: _(____)_____

Reason for medical records request: _____

_____ I authorize the release of records, including those which may contain confidential information (testing, diagnosis, or treatment), confidential communicable disease related information, information related to mental health and the treatment thereof.

*please initial if you want to authorize your records to be FAXED. _____

Photocopies of information to be released:

_____ Discharge Summary	_____ Operative Report	_____ Pathology Reports
_____ Consultation	_____ Laboratory Results	_____ Mammography Results
_____ Ultrasounds	_____ Other: _____	

***ALL INFORMATION MUST BE COMPLETED BEFORE RECORDS ARE COPIED ***

I hereby authorize: _____

Phone #: _____ Fax#: _____

Address: _____

To be Released to: _____

Phone#: _____ Fax#: _____

Patient Signature: _____ Date: _____

Witness: _____ Copy & Delivery Date: ____/____/_____ **F or M**

If the records are forwarded to another physician due to insurance changes or medical necessity, there will be no charge. In all other situations there will be a \$35.00 processing fee. Processing time for medical records is 7-10 business days. We accept cash, check or credit card (MC or Visa).