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Record Release of Information

Patient Information:

Name_____ Date of Birth_____

Address_____

Phone Number _____

Signature_____ Date:_____
(If not patient, State Relationship)

Witness Signature_____ Date:_____

I, _____ , hereby authorize my medical records released to:

Patient/Clinic Name: _____

Physician's Name _____

Address: _____

Phone Number: _____ Fax Number: _____

Records desired (please check all that apply):

- € Dates of service from _____ to _____
- € Most recent pathology report
- € All of my records
- € All of my pathology reports
- € Other: _____

There will be a processing fee of $10.00 plus $0.50 per page

Payment is due at time of request. Release is valid for 30 days.
If additional copies are desired after the valid date, there will be an additional 12.00 charge