

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: _____

Please allow 2 weeks to process record requests.

There will be a processing fee of \$10.00 plus \$0.50 per page. This must be paid before records can be prepared for release. There is an additional fee for postage.

Request is valid for 30 days. If additional copies are desired after the valid date, there will be an additional 12.00 charge.

Record Release Payment Information:

<p>Payment Information:</p> <p>Cardholder's Name: _____</p> <p>Credit Card Number: _____</p> <p>Exp. Date: _____ CVC Code: _____ Zip code: _____</p>
