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MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Information:

Patient Name: _____ **Date of Birth:** ____/____/_____

☐ **Send Records To:** ☐ **Request Records From:**

Recipient Name: _____

Organization (if applicable): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Fax Number (if applicable): _____

Records to Release:

☐ Complete Medical Record ☐ Progress Notes

☐ Pathology Reports ☐ Laboratory Results

☐ Records from Specific Date(s): _____

Reason for Request:

_____

_____

Delivery Method:

☐ Mail (Fees Apply) ☐ Patient Pickup ☐ Fax

Authorization:

I authorize the release of my medical records as described above.

Signature: _____ **Date:** ____/____/_____

- A parent or legal guardian must sign for patients under 18 years of age.
- Fees: $25 For the first 20 pages, each additional page is .50 cents.
- If you are requesting records to be mailed postage will be an additional charge. Postage is estimated at $2 for the first 20 pages