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MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician or person listed below.

Patient Name: _____

Date of Birth: _____

Please Check One:

_____ Please release last 2 years of exams. Enclosed is payment for $40 (note records will not be printed until payment has been received by our office.

_____ Please release full medical record. Enclosed is payment quoted by office (Call office for Quote)

Please release my medical records to:

Name:_____

Address:_____

Phone #:_____

Fax #:_____

_____ _____

Patient or Guardian Signature **Date**