Medical Records Release Authorization

<u>*PLEASE ALLOW 7-10 BUSINESS DAYS TO PROCESS RECORDS*</u>

Patient First Name: _____ Last Name: _____

Date of Birth: _____ Date of Request: _____

Contact Number: _____

I, _____, hereby authorize release of my medical records to the following:

Name: _____

Address: _____

FAX: _____ PHONE: _____ EMAIL: _____

<u>PREFERRED METHOD: (circle one)</u>

EMAIL **FAX** **IN-OFFICE PICK UP** **MAILING ADDRESS**

FOR OFFICE USE ONLY:

Description	Employee Name	Date of Completion
Release Form		
Payment Receipt - $40.00		
Provider Approval Signature		
Billing Department		
Medical Record Department		
Release of Record		