REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Address: _____

Date of Birth: _____ SSN: _____

I hereby authorize the release of my medical records including laboratory and diagnostic data:

FROM: _____ TO: _____

_____ _____

_____ _____

RECORDS: (Please check all that apply)

____Operative Reports ____Laboratory Results ____Office Records

____ Ultrasound/X-ray ____ Pathology Reports ____Other: _____

_____ I plan to return to this practice for care. Please keep my records active.

A prepaid minimum fee of $10.00 is charged for 0-13 pages. If your request is more than 13 pages, you will be charged the fee established by the NC State Legislation which is .75 per page for the first 25 pages, .50 per page for pages 26-100 and .25 per page for each page in excess of 100 pages. These fees are prepaid and will be charged each time you request medical records. Your records will be available within a reasonable time frame as the office legally has 30 days to provide records.

Signature: _____ Date: _____

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