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MEDICAL RECORD RELEASE

Our practice is committed to securing the privacy of your health information. Accordingly, we must notify you that you have the right to inspect or copy the information to be used or disclosed and the information may be subject to re-disclosure by the recipient and no longer protected under HIPAA.

Request will be processed 30 days from receipt date.

At my request I authorize the release of medical records:

FROM:

(Name of practice/physician requesting records from)

_____

_____

_____

TO:

(Who you want the records sent to)

_____

_____

_____

Please release:

☐ All medical records ☐ Photographs* ☐ pathology reports ☐ Histology slides

Patient name: _____ Date of birth _____

Address: _____ Social Security # _____

_____

Phone: _____

Signature: _____ Date: _____

(If patient is a minor, parent/legal guardian sign here)

Relationship: _____

_____ *__NOTE__: There may be a charge for record copying of $25. To get a reproduction
(Initial) of any photographs there is a fee of $3/photograph