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Authorization to Release Medical Records

THIS AUTHORIZES YOU TO PROVIDE A COPY, SUMMARY OF MY MEDICAL RECORDS **(AS INDICATED BY THE CHECKMARKS)**.

( ) Records concerning the following condition(s):
____
____

( ) Records of care for the following dates:
____
____

( ) Complete Medical Records.

( ) Other: ______________________

Release My Records From:
____
____
Phone: (______)____________________
Fax: (______)____________________

Release My Records To:
____
____
Phone: (______)____________________
Fax: (______)____________________

Reason for release. Please circle one:

Transferring doctor / 2nd Opinion / Specialists / Moving Away / Other, please explain below.

Name:____________________________**DOB:** _________/_________/_________

SSN#:____________________________**Phone:** (______)____________________

Address: ____
Street **City** **State** **Zip**

I UNDERSTAND THAT YOU WILL PROVIDE THIS INFORMATION WITHIN 15 BUSINESS DAYS FROM THE DATE OF REQUEST. *THERE IS A $25 CHARGE FOR THE FIRST 20 PAGES AND 50 CENTS PER PAGE AFTER THAT*.

APPOINTMENT DATE: ____________________

APPOINTMENT TIME: ____________________

FOR OFFICE USE ONLY

Records were picked up today,
________________. _____ (Intl)
Records were mailed on
________________ by_____(Intl)
Records were faxed on
________________ by_____(Intl)

Physician approved on: __________
(Date)
Phys. Signature: ______________

SIGNATURE: ____________________________**DATE:**__________

IF YOU RECEIVED THIS INFORMATION IN ERROR, PLEASE CONTACT OUR OFFICE AT (940) 484-7100 AND DESTROY DOCUMENTS.