

RELEASE OF INFORMATION

***** IMPORTANT *** PLEASE READ *** IMPORTANT *****

You are entitled to a COPY of you Medical Records, and of this Release of Information – release form. Copying of Medical Records is performed once per week.

Patient Name: _____
Birth Date: _____ Social Security#: _____
Daytime Phone #: _____

I HEREBY REQUEST THE FOLLOWING INFORMATION:

- | | | |
|--|----------------------------------|--|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> X-Rays | <input type="checkbox"/> Diagnostic Test Reports |
| <input type="checkbox"/> OP Reports | <input type="checkbox"/> Lab | <input type="checkbox"/> Film Copies |
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Billing | |

FROM MY DOCTOR: (PLEASE CHECK BOX AND FILL IN YOUR DOCTOR'S NAME)

DR. _____

THIS INFORMATION WILL BE USED FOR:

PLEASE SEND TO:

AT ADDRESS:

- | | | |
|---|--|------------------|
| <input type="checkbox"/> Myself | <input type="checkbox"/> Attorney | _____ |
| | | (NAME) |
| <input type="checkbox"/> Treating Doctor | <input type="checkbox"/> Insurance Co. | _____ |
| | | (STREET ADDRESS) |
| <input type="checkbox"/> State Disability | | _____ |
| | | (CITY) |

BY SIGNING THIS FORM, I REQUEST AND AUTHORIZE RELEASE OF THE MEDICAL INFORMATION NOTED ABOVE. THIS AUTHORIZATION IS VALID FOR ONE YEAR UNLESS OTHERWISE NOTED. (_____)

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY:

Request Completed By _____ Date _____

_____ Mailed _____ Faxed _____

Picked up by: _____ Patient _____

_____ Other _____