Authorization for Medical Records Release to Patient

PATIENT NAME: ______________________________________

DATE OF BIRTH: ______________________________________

ADDRESS: ______________________________________

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I understand and agree to the financial responsibility associated with my request which includes: copying charges, postage if required, and handling fees. I understand I am responsible for the following fees:

1 – 25 page(s)	$0.75 / page	$_____________
26 – 100 pages	$0.50 / page	$_____________
Postage / Fax Fee (if required)	$0.75 / page	$_____________
TOTAL		$_____________

- *Requests from insurances, attorneys, or other outside agencies will not be completed by our office. These requests should be made through Infostat.*

BY SIGNING BELOW, I DO HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AND AGREE TO THE FINANCIAL REPSONSIBILITY FOR THE COST INCURRED FOR THE RELEASE OF RECORDS.

______________________________________ ______________________

Signature of Patient (or Legal Guardian) Date

______________________________________ ______________________

Printed Name of Patient (or Legal Guardian) Date