Medical Records Release

I, _____, date of Birth_____herein request my records from:

Doctor or Office Holding Records:

Doctor/Office: _____

Address: _____

City, State, Zip: _____

Phone/ Fax#: _____

Please forward a copy or summary of the following, from my medical record:

___ Complete Medical Record

___ Lab Report(s) - Which reports: _____

___ Photo(s) - Which photos: _____

___ Other _____

Records Faxed OR Mailed To: (Please circle one):

Doctor/ Office: _____

Address: _____

City, State, Zip: _____

Phone/FAX#: _____

Records requested for yourself:

- **There is a Labor Fee of $15.00 and a $0.25 per page charge.**
- **If you would like records mailed, there is a fee for actual postage.**
- **If necessary to put records onto a CD instead of printing, there is a $10.00 CD charge instead of a per page fee.**

Fees above must be paid before records are given.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____