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## AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Last 4 digits of SS#: _____ MRN: _____

**Person/Organizations providing information:**

_____

_____

_____

**Persons/Organizations receiving information:**

_____

_____

_____

**Information to be disclosed, covering the period of health care: From _____ To _____**

☐ Complete health record, OR select from the following:

☐ Office Notes ☐ Pathology reports ☐ Procedure Notes ☐ Laboratory Tests

☐ Radiology reports ☐ Other (please specify) _____

Signature of Patient _____ Date _____

**Patient Fees:** There is a charge to you for a personal copy of your records. Patients will be charged $0.50 cents per page for the first 50 pages and $0.25 per page for any subsequent pages. If records are to be mailed, patients are also required to pay for postage. Medical records fees are due before records will be issued.

The federal privacy act of 1974 (P.L.93-579) and other governmental regulations have heightened the need for security in the transfer of privileged communications. The information you request will be from records whose confidentiality is protected by these regulations and prohibits anyone from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.