**MEDICAL RECORDS RELEASE AUTHORIZATION**

I hereby authorize the use of disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize and request you to release my records to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

please Select one delivery method:

❒ **REGULAR MAIL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR** ❒**FAX:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Mailing Address* *Fax Number*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*City, State, and Zip*

**Please forward a copy of the following medical records:**

\_\_\_\_\_\_\_ COMPLETE MEDICAL RECORDS \_\_\_\_\_\_\_ CONSULTATION REPORTS \_\_\_\_\_\_\_ MEDICATIONS/ALLERGIES

\_\_\_\_\_\_\_ BIOPSY REPORTS \_\_\_\_\_\_\_ LAB REPORTS \_\_\_\_\_\_\_ SURGICAL PROCEDURES

**For the following dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

in accordance to Statute 64B8-10.003 Costs of Reproducing Medical Records:

I understand and agree that I am financially responsible for the following fees associated with my request of copying charges and production of my information. I understand that the charge for this service is as follows: For the first 25 pages, $1.00 per page after 25 pages a charge of 0.25 cents per additional page.