

**OUTGOING RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_, legal guardian of patients listed below, hereby request and authorize you to release the records of:

Name _____	DOB _____
Name _____	DOB _____
Name _____	DOB _____
Name _____	DOB _____

The information to be released will cover the time period from \_\_\_\_\_ to \_\_\_\_\_, and will include:

- Immunizations only (no charge)
- Entire Record       Include previous medical records
- Specialist Reports \_\_\_\_\_
- Other: \_\_\_\_\_
- Exception: I do NOT give permission to release:** \_\_\_\_\_

Leaving the practice?  YES  NO

Reason for Leaving: \_\_\_\_\_

Delivery Method:  Pick Up by \_\_\_\_\_

Fax to \_\_\_\_\_

Mail to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Record Release Fee: \$15 each for the first two patients, \$10 for each additional patient**

We accept cash, check and all major credit card payments.

I understand that requests for Entire Records will take up to ten business days to complete.

**The record release process will begin once payment is received.** Entire Records cannot be faxed.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Telephone Number

*For Internal Purpose Only:*

Manager's Initial \_\_\_\_\_ Date \_\_\_\_\_

Faxed Date \_\_\_\_\_

Mailed Date \_\_\_\_\_

Staff Initial \_\_\_\_\_