

**OUTGOING RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_, legal guardian of patient(s) 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 \_\_\_\_\_

- Immunizations only (\$10 fee for inactive patients only)
- Entire Record Include medical records from previous physician (cannot email)
- 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: \_\_\_\_\_ Fax # \_\_\_\_\_

Email: \_\_\_\_\_ (Not applicable for full records)

Mail to: Name: \_\_\_\_\_

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

Record Release Fee: **\$20 each patient for the first two patients, \$10 for each additional patient.**

We accept cash, check and all major credit cards. You may also visit our website to pay online.

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.**

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

\_\_\_\_\_  
Date

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

For Internal Purpose Only:

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

Staff Initials: \_\_\_\_\_

Faxed date: \_\_\_\_\_

Mailed date: \_\_\_\_\_

Emailed date: \_\_\_\_\_