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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTHCARE INFORMATION

Patient Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Telephone: _____

Date of Birth: _____

Social Security Number: _____

Send Records To: _____

I, above named (or parent/guardian of above named) authorize the copying of my medical records, including x-rays (if applicable) and consent that they be mailed to me at the above address or to a third party as indicated above. I agree to pay for all copying expenses. Medical Record Copies will be ready in 10-14 days from the date payment is received. The total cost is \$_____.

PATIENT OR PARENT/GUARDIAN SIGNATURE

DATE

WITNESS/RECEIVED BY

DATE

Faxed Forms will be treated as Original Signatures.