Authorization for Release of Medical Records to Patient

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $0.75 per page up to 25 pages and $0.50 per page from 26 - 500 pages, and $0.25 per page for all pages over 500. There is also a $5.00 handling fee and actual postage if applicable.

1 - 25 page(s)	$0.75 per page	$_____
26 – 500 pages	$0.50 per page	$_____
>500 pages	$0.25 per page	$_____
Handling Fee	$5.00	$_____5.00
Postage/Fax Fee	(if applicable)	$_____
TOTAL		**$_____**

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS AND FINANCIAL RESPONSIBILITY FOR COST INCURRED FOR RELEASE OF THOSE RECORDS:

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian