

RECORD RELEASE AUTHORITY

TO: CITY CARE FAMILY PRACTICE, P.C.

I hereby request a copy of my following medical information from ___ / ___ / ___ to ___ / ___ / ___ .

(please check off)

- All medical records, including any records related to;
Sexually Transmitted Disease, Drug and Alcohol Abuse Treatment and Mental Health or Mental Illness, if any.
- Doctor's note related to the follow treatment or condition only: _____
- Laboratory Test Results
- Immunization Records
- HIV related Records (additional authorization required)
- Other(Please specify): _____

Reason for Record Release (required): _____

Fee for Copying

We may charge a fee for the costs of copying or other supplies we use to fulfill your request.
The standard fee is \$0.75 per page. You will be notified when the copy is ready for you to pick up.

If you wish the copy to be mailed, please indicate the destination by filling out the following section.

Recipient			
Address	City	State	Zip Code
()	()		
Telephone Number	Fax Number		

Fee for Mailing

If you request the copy to be mailed to you or other location, you will be charged for the actual mailing cost.
A full payment of the fees will be expected prior to mailing. Please be aware that the package could be lost in the mail and/or disclosed to the public. The same fees will be incurred for reproduction.

Patient Name (type or print) Date of Birth

Patient Signature Today's Date Date of Request

Name of Patient Representative (type or print if applicable) Relationship to Patient

Signature of Patient Representative (if applicable) Today's Date Date of Request

Contact Address City State Zip Code Phone Number

This authorization expires on _____ or in 90 days from the date signed unless otherwise specified.

Office use only Initiated by: _____ Completed by: _____
Date: _____ Date: _____