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MEDICAL RECORD RELEASE REQUEST- (Must FAX back to our office)

To Dr. _____:

Please forward a hard copy of my medical record to:

RECIPIENT'S NAME **CONTACT NUMBER**

MAILING ADDRESS

CITY **STATE** **ZIP**

Below is my personal information.

PATIENT FIRST NAME **PATIENT LAST NAME**

DATE OF BIRTH **SSN**

CONTACT NUMBER **EMAIL (OPTIONAL)**

SINCERELY,

_____

DATE & PATIENT'S SIGNAUTARE

******There is a fee may charge by the doctor for the shipping and handling******

General Information:

FEES FOR OBTAINING MEDICAL RECORDS IF THE CHART IS *NOT* IN STORAGE:

- **$30 FOR THE FIRST 45 PAGES**
- **$40 FOR 46 TO 70 PAGES**
- **$50 MAXIMUM FOR 70+ PAGES**

FEES FOR OBTAINING MEDICAL RECORDS IF THE CHART IS AT AN OFFSITE STORAGE FACILITY:

- **ALL THE CHARTS WILL SEND TO STORAGE IF PT. DID NOT HAVE ANY APPOINTMENT WITHIN 2 YEARS**
- **SEE ABOVE PRICE LIST, PLUS $30 FEE (SERVICE CHARGED BY THE STORAGE COMPANY)**

******$50 ADDITIONAL FEE PER PAGE FOR EVERY ADDITIONAL DOCTOR DICTATION.**

******FEES MUST BE RECEIVED BEFORE THE MEDICAL RECORDS ARE SENT OUT.**
TURNAROUND TIME WILL BE 10 TO 15 BUSINESS DAYS AFTER THE FEE IS RECEIVED.