EVGHA

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MEDICAL RECORD RELEASE FORM

_____ _____

Patient Name *Date of Birth*

Your Requested Records should be ready within 3 – 5 business days of the signing and submission of this Document. THERE WILL BE A $15 CHARGE FOR YOUR PERSONAL MEDICAL RECORDS.

From: Self/Dr./Practice: _____

Address: _____

Phone/Fax: _____

Medical Information Requested:

☐ *All Records*

☐ *Specific Records from* _____ *to* _____

Medical records request Fees:

- ***Print-*** I understand that you may charge me a fee of up to $15.00 if I request my entire chart for personal use.
- ***Oversized Records-*** I understand that you may charge me a fee of up to $25.00 if I request my entire chart for personal use and it exceeds 100 pages.
- ***NO CHARGE-*** Any records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

_____ _____

Patient Signature Date

_____ _____ _____

PCMA Doctor Signature Date