AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Social Security#:_____/_____/_____

DOB: _____/_____/_____

I hereby authorize the release of records to:

Name:_____

_____

_____

Records requested:_____

For the purpose of:_____

PLEASE READ AND SIGN

These records are being provided to you free of charge this time along with any updates requested. However due to the increased cost of doing business any subsequent request for another complete set of records will result in a charge.

Charges are as follows: Medical Records - $25.00 for first 20 pages. .50 a page thereafter
Billing Records - $25.00 flat fee

Patient Signature:_____ Date:_____

In order to comply with regulations for Health Insurance Portability and Accountability Act (HIPAA) governing the confidentiality of patient information a fully completed HIPAA compliant, Authorization to Release Medical Records must accompany each request for medical records even though you may have already obtained a signed consent from the patient.

We are sorry for any inconvenience this may cause, but the laws were enacted to protect the confidentiality of medical information. Physicians must comply with HIPAA privacy standards by requiring a fully completed form with all required information before releasing patient information. Thank you for your cooperation.

This Authorization to Release Medical Records will expire in six months from the date of the patient signature