Medical Records Release

Patient Name **Date of Birth**

Daytime Phone

Please circle one:

I request and authorize OHMC to: Release To Obtain from

Name:

Address:

City:

State:

Zip:

Phone: Fax:

You may use or disclose the following health care information (check all that apply): Patients who request more than the last 2 years of their records may be charged a $10 service fee. All payments are required prior to copying. All records are burned to a CD, faxed or e-mailed. If paper copies are requested, there will be additional charges.

Chart Notes Labs / Pathology X-rays / Diagnostics Immunizations

Patient Visit Summary All Records Most Recent Specialist(s) Visit Billing Last Well Child Check Growth Chart

Pick up

Where?

Faxed

Time Frame Requested Mailed E-mailed E-mail address

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have

marked NO and initialed it.

_____ YES _____ NO _____ INITIALS

Signature/Legally Responsible:

Party Relationship to Patient:

Date: