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Original Records Release from our office to patient

Patient Name: ____ **Patient ID #:** _______________________
[Birthdate or Social Security Number]

Address1: ____ **Home Phone:** _____________________

Address2: ____ **Work Phone:** ______________________

City/State/Zip:_____________________________________

I hereby request Dr. ______________________________________ **to allow me to obtain my medical record.**

I understand that I will receive a copy of the original record and that these released records are my responsibility.

I further understand that:

1) All healthcare providers maintain certain protected health information about me as a patient, such as medical and billing records, and records that are used, in whole or in part, to make decisions about me, my treatment, or billing for services rendered.
2) I have the right to inspect and obtain a copy of my above mentioned protected health information maintained by the above listed physician.
3) My request must be made in writing using this form, which must be completed prior to the above listed physician providing me with the requested information.
4) If I request the above listed physician to copy and provide or mail the requested information, the office may charge me for the requested information. THE OFFICE WILL CONTACT ME REGARDING THE FEE BEFORE RELEASING THE RECORDS.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney