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Release of Medical Records

PATIENT NAME: _____ DOB: _____

STEP 1: How would you like to receive your records?

- PICK UP : (_____) _____
(please provide phone # to contact once records are ready to be picked up)
- E-MAILED: _____
- FAX : _____
- MAILED : _____

STEP 2: Please Indicate the type of records that you need:

- CONSULTATION NOTES
- MRI REPORTS
- BILLING
- X RAY IMAGES
(can only be emailed or burned into a CD to be picked up (\$10Cash for CD))
- OTHER : _____

Signature of Patient:

Date Signed:
