PATIENTS FIRST
Get in. Get out. Get better.

Medical Records Release

Date:_____

Patient Name:_____ Date of Birth:_____

I hereby authorize: **PATIENTS FIRST**

to release my medical records to _____

at Fax # _____ OR

at address: _____

_____

_____

Please check all that apply to send:

- ○ All Records
- ○ From _____ to _____ date(s) of service
- ○ Drug & alcohol abuse records
- ○ Psychiatric or Psychotherapeutic records
- ○ Sexually transmitted disease and HIV results
- ○ Other _____

_____ _____

Patent Signature Date

_____ _____

Witness Signature Date

For the following information for any of our locations: Address, Fax or Phone Numbers, please visit our website at www.patientsfirst.com.

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INVOICE FOR MEDICAL RECORDS

Date: _____ **Center**: _____

Company (if applicable): _____

Address: _____

Phone: _____ **Fax:** _____

Patients Name: _____ **DOB:** _____

Claim#/Record#/Chart # _____

Private Patient Copying Costs:

Per page for pages 1-25	Pages: _____ x $1.00 =	$_____
Per page for pages > 25	Pages: _____ x $0.25 =	$_____

Workers' Comp Copying Costs:

Per page	Pages: _____ x $0.50 =	$_____

TOTAL DUE: **$**_____

Please make check payable to Patients First
Medical records will be sent upon receipt of payment.