MEDI-COPY
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1) PATIENT IDENTIFICATION:

Patient Name:

Address:

City: State: Zip:

Daytime Phone#: E-mail:
(pay online & receive records quicker)

DOB: SSN:

2) RELEASE RECORDS TO:

☐ Same as above

Name:

Address:

City: State: Zip:

Phone#: Fax#:

Email:

3) INFORMATION REQUESTED & PURPOSE: (*FEES MAY APPLY. PLEASE SEE FEE SCHEDULE IN SEC. 4 AND INITIAL.*)

Dates of Treatment to be Released:

Dates from: _____-_____
OR Specific Date: _____
OR Past _____ Years

Specific Categories (if applicable)

☐ All Records	☐ Radiology Reports	☐ Obstetrics
☐ Office/Clinic Notes	☐ Cardiac Reports	☐ History & Physical
☐ Lab Results	☐ Pathology Reports	☐ Operative Notes
☐ Pathology Reports	☐ Lab Results	☐ ER Reports

☐ Other_____

☐ Abstract (H & P, Discharge Summary / ER, Op. Notes, Path & Radiology Reports)

Purpose of Disclosure:

☐ Personal Record	☐ Disability Determination	☐ STD/LTD Benefits
☐ Litigation/Legal	☐ Insurance	☐ Transfer of Care (Last two years sent w/o charge)

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes appropriately. Otherwise your records will be released as specified above. I authorize and any employees and/or agents to release the information specified to the organization, agency or individual named on this request with the exception of:

Initials_____Substance abuse **Initials_____AIDS/HIV/STD's** **Initials_____Psychological or psychiatric conditions**

4) FEE SCHEDULE:

I acknowledge that I may be charged for requesting this information: _____ (initial)

Fee Schedule		Delivery Method		Additional Options	
Pages 1-5	$20.00		**FREE (No add'l charge to Fee Schedule)**	Records on CD	☐ $7.00
Pages 6+	$0.50/page	Fax			
		E-Mail			
		Postage	At Cost (If Applicable)		

5a) PATIENT'S SIGNATURE

I hereby authorize (DR NAME) to release or disclose to the above-named person(s) or organization in **Part 2** all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

This office uses an outside copy service, Medi-Copy Services, to copy its medical records. All copy fees comply with applicable state law. Please make your check payable to Medi-Copy Services, or by phone using your credit or debit card. Pursuant to 63-2-102 (c), Medi-Copy Services, Inc. requires payment to be made prior to the completion of your request.

Patient's Signature: Date:

5b) If this authorization form is signed by a personal representative for the individual patient:

Signature: Date:

Relationship to patient:

MEDI-COPY SERVICES, INC. *simple. secure. solutions.*
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