MEDICAL RECORDS RELEASE FORM

Patient Name:____ **Date of Birth:**_________________

Address:____

Phone Number (Daytime):____________________________ **(Evening):**______________________________

I request and authorize CFA to release the following healthcare information:_______________________

____

Specified Dates of Service:____

I will pick my records up ☐

Mail requested records to: ____

____

____

____

Fax requested records to: ____

Include name and fax number of recipient

I understand the fee for copying or faxing records is 50 cents per page. If the records are mailed, the cost of postage will be added. A $25.00 service charge will be applied to records stored offsite.

It may take 5-7 business days to process your request.

Patient's Signature: ____ **Date:**___________

Spouse/Partner Signature: ____ **Date:**___________

(Required if their records are included the request)