

RECORD RELEASE AUTHORIZATION

I, _____ hereby request and authorize you to release the record(s) of:

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

The medical records will be mailed to:

Name _____

Address _____

I will be picking up the medical records.

Name _____

OR Telephone # _____

Fee:

I have enclosed the record release fee (\$10/child).

I will pay upon pick-up.

Check

Check# _____ Amount \$ _____

OR

Credit Card

Amex ___ Visa ___ MC ___ Discover ___

CC# _____ Exp _____

Cash (*Please do not mail cash.*)

Reason(s) for request:

I understand that the records will take five (5) days to complete and will be released upon receipt of payment.

Signature of Responsible Party

Date of Signature

For Internal Purpose Only:

Manager Initial _____ **Date** _____

Billed Date _____

Mailed Date _____

Staff Initial _____