



**MEDICAL RECORDS RELEASE/AUTHORIZATION FORM**

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

ATTN.: MEDICAL RECORDS DEPARTMENT

**I AM WILLING THAT A PHOTOSTAT OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.**

PLEASE MAIL TO FORMSCOPE, LTD. A COPY OF MEDICAL RECORDS CONSISTING OF:

_____ EMERGENCY ROOM RECORDS	_____ OPERATING ROOM RECORDS
_____ RECOVERY ROOM RECORDS	_____ NURSING NOTES
_____ ANESTHESIOLOGY RECORDS	_____ PHYSICIAN'S ORDERS
_____ NURSNG MEDICATION NOTES	_____ DISCHARGE SUMMARY
_____ MEDICATION ADMIN. RECORDS	_____ OTHER _____

PERTAINING TO HOSPITALIZATION FROM \_\_\_\_\_ 20\_\_\_\_ TO \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
PATIENT ACCOUNT NUMBER

\_\_\_\_\_  
CITY

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
STATE/ZIP

**NOTE: PRIOR APPROVAL OF CHARGES MUST BE OBTAINED IF FEES EXCEED A REASONABLE CHARGE OF 50 CENTS A PAGE FOR UP TO FIFTY PAGES AND 25 CENTS A PAGE THEREAFTER, AND A FEE FOR SEARCHING, HANDLING, AND MAILING THAT DOES NOT EXCEED TEN DOLLARS.**

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE OF SIGNATURE

By my signature above, I acknowledge the release of any Protected Health Information (PHI) to the individual(s) designated on this release form. This protected health information is to be disclose under this authorization at my request, as permitted by 164.508©(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I acknowledge that I have received a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to the Company.

This release will remain in effect and valid for 90 days from date of signature