NEW MEXICO Foot & Ankle INSTITUTE

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MEDICAL RECORDS RELEASE AUTHORIZATION

Date: _____

Patient Name: _____ DOB: _____ PH#_____

I, _____, hereby authorize the release of my protected health information and request the release of my medical records.

The following charges apply:

< 10 pages (visit notes only) = No Charge
> 11 pages (copied to CD) = $20.00
> 11 pages (printed/hardcopy) $1.00 per page
X-ray Images (copied to CD) = $10.00

This protected health information may include, but may not be limited to:

[ ] Records of Treatment / Visit Notes
[ ] Lab Test Results
[ ] X-Ray Images
[ ] Other: _____

Date Range or Specific treatment dates of request: _____

Records can be picked up at the location of which you requested, and a valid ID must be presented at the time of pick up. Payment is due at the time of pick up.

If records are being picked up by someone other than patient:

Recipient Relationship to Patient: _____

Recipient Name (Please Print): _____

_____ _____
Recipient Signature Date:

_____ _____
Patient Signature Date:

FOR OFFICE USE ONLY:

Amount Collected: $_____ Valid ID Verified / Staff initials _____ Date processed _____