FAMILY PRACTICE ASSOCIATES, P.C.

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Request for Release of Medical Records From FPA

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Date of Request: _____ (Please allow up to 1 week for copying records.)

I hereby request that my medical records be released for dates of service from _____ to _____ with the exception of:

___ Progress Notes ___ Psychological or Psychiatric Conditions
___ Drug or Alcohol Abuse ___ STDs / Communicable Diseases Other _____

I understand this information will be used for: _____

Please send records to: Practice Name and/or Provider Name: _____

Address: _____

City / State / Zip: _____

Phone: _____ Fax: _____

We are happy to send medical records to a Medical Facility or Physician's Office for **NO CHARGE**.

If patients are requesting medical records for personal use, our fees are as follows (please choose one):

- ☐ $0 – 0-10 pages of medical records to be picked up or mailed
- ☐ $15 – 11-150 pages of records to be picked up
- ☐ $25 – 11-150 pages of records to be **mailed**
- ☐ $25 – 151+ pages of records to be picked up
- ☐ $35 – 151+ pages of records to be **mailed**

Please enclose check payable to Family Practice Associates OR charge to a credit card:

Name on card: _____ *Billing Address:* _____

Card #: _____ *Expiration:* _____ *Security Code:* _____

SIGNATURE: _____ **DATE:** _____

Date Mailed / Picked-Up: _____ *Signature:* _____

Type of ID presented: _____ *Daytime Phone:* _____