Patient Consent for Release of Health Information

Patient Information:

Full Name: ________________________________ **Date of Birth:** ____/___/________

Address: ____

City: ___________________________ **State:** _____ **Zip Code:** ______________

Phone (Daytime): (____) ______ - _________ **E-mail:** ______________________________

Information Requested for Release

☐ **1 year abstract of records** (includes Office notes, Operative report, labs, testing)

☐ **2-year abstract of records** (includes Office notes, Operative report, labs, testing)

☐ **Dates of Service Requested:** ____/___/________ **through** ____/___/________

☐ **Office Visit Notes** ☐ **Procedure/ Operative Report** ☐ **Labs** ☐ **Injections**

☐ **Physical Therapy** ☐ **Billing Records** ☐ **Other (specify):** _________________

☐ **Radiology Disk:** __________________________________ **($10.00 charge for Disk)**

Record Delivery Method

☐ **E-mail** (sent via direct link to a specified email / Quick and secure)

☐ **Mail** ☐ **Fax** (please provide mailing address as well in the instance file is too large to fax)

Release Records To

Name/ Facility: _______________________________ **Attention:**_________________

E-mail: ____

Fax Number: (_____) ________-______________

Mailing Address: ____

City: ______________ **State:** _____ **Zip Code:** ___________

Signature: (sign below)

Patient Name / Personal Representative **Date:**

Signature: _____________________________ ____/___/________

Your medical records request will be processed by our partnered company Acton Corporation. If you need assistance or have a question, please call (659) 734-2937.

Acton

Treating Information with Care