



Medical Records Release to Patient

Date of Request: _____

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____

I would like a copy of my protected health information. I understand that a copy of my records will be furnished within 30 days after the date of receipt of the request and there will be a flat fee of \$10.00 and then \$.75 per page. If your records are mailed there will be postage added.

Total pages _____ Amount Due \$ _____

PLEASE USE THE DELIVERY METHOD BELOW:

- Please fax my records to: _____
- Please mail my records to: _____
- I will pick up my records at Idaho Skin Surgery Center, PC.

Patient Signature: _____

Date: _____

Relationship to patient (if requestor is not the patient)

office use only

Print Patient Name: _____

Date completed: ____/____/____ Completed by: _____