INFECTIOUS DISEASE CONSULTANTS

Patient's Full Name: _____ **Patient's Date of Birth:** _____

I authorize Infectious Disease Consultants to:

☐ **To release copies to** ☐ **To obtain copies from**

Physician Name: _____

Address: _____ City and Zip: _____

Check Information that may be released, note only records pertaining to your doctor's orders may be released.

☐ **Complete Chart** ☐ **Progress Notes** ☐ **Culture Results** ☐ **Lab Results** ☐ **CT/MRI Films**
☐ **Radiology Reports** ☐ **Medication list** ☐ **Surgery Notes** ☐ **Other:** _____

This information is for the purpose of:

☐ **Continued Treatment** ☐ **Insurance** ☐ **Second Opinion** ☐ **Moving** ☐ **Other**

To be: ☐ **Picked Up** ☐ **Mailed** ☐ **Faxed to** _____

I hereby authorize this practice to release my medical records, including, but not limited to all of the above. By signing this consent, I completely release the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. I also understand this authorization is only valid for 12 months.

_____ _____

Patient/Guardian Signature **Date**

Fee for medical records start at $25.88, this doesn't include copying cost. Copying cost are as follows: for a records which is in paper form shall not exceed $0.97 per page for the first 20 pages of the patient's records which are copied, $0.83 per page for pages 21-100 and $0.66 for each page copied in excess of 100 pages. We will process your request upon receipt of said payment.

For Office Use Only

Records Paid $:_____ on ___/___/___ CASH CC Check #_____ Records Sent ___/___/___

Initials: _____ Physician Signature: _____