RECORDS RELEASE MEDICAL AUTHORIZATION

Patient's Name_____

Address_____City_____

State____ Zip_____ Phone_____ DOB_____SSN_____

Which records are needed: _____

Reason for transfer/request: _____

I, the undersigned, do hereby authorize and direct you to

[ ] Furnish records ***TO*** Precision Family Medicine from:
[ ] Release records ***FROM*** Precision Family Medicine to:

******IMPORTANT NOTICE: Per Precision Family Medicine Practice Policy, we only copy, print, mail or fax PFM records. We do not copy, print, mail or fax other Doctor's medical records. Please contact your past Dr. for these records.**

Name_____

Address_____City_____

State_____ Zip_____ Phone_____ Fax _____

Check how records are to be received: Mail _____, Pick-Up _____, Fax _____

(If **all** records are requested, **PFM will not fax records**)

PRECISION FAMILY MEDICINE
1428 West Hebron Parkway, Ste 110, Carrollton, Texas 75010
Phone 972-939-4555 * Fax 972-939-7020

I understand that my request will be processed within the timeframes set forth by state law or within 30 day, whichever is less. I understand that I am responsible for cost for copies.
A copy of this authorization is as valid as an original and will expire 6 months from the date below.

Medical Records Request Fees:

- ***Print -*** I understand that you may charge me a fee of up to **$25.00** if I request my entire chart for personal use
- ***Oversized Document –*** I understand that you may charge me a fee of up to **$30.00** if I request my entire chart for personal use and it exceeds 100 pages
- ***NO CHARGE-*** Any Records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

I UNDERSTAND THAT PRECISION FAMILY MEDICINE DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS OR FACILITIES.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

WITNESS: _____