**Medical Records Release Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

hereby authorize Elements of Care OBGYN to release medical records on:

Patient Name: Birth Date:

Patient Address:

Phone Number:

Information shall be released (sent) to:

Address:

Fax:

If records are released directly to you or your authorized individual, please check how you would like your records to be released: Digital Paper

**Fees**:

I understand that a copy fee of $25.00 will be charged for records that are directly released to the patient. We do not charge for physician-to-physician transfers of medical records.

**Authorized Signature**: **Date**:

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I authorize the following individuals to pick up my records (must bring picture ID):

Relationship to patient: