Medical Records Release Form

Patient's Name (Print): _____Date: _____
Date of Birth: _____Date of last visit: _____
Signature: _____Witness:_____
Representative's Name (Print): _____Relationship: _____
(Please attach legal documentation of authority if signer is not patient)

I authorize information to be disclosed to the following individual or organization:

Name: _____
Address: _____
City: _____State:_____Zip:_____
Phone: _____ Fax: _____

I authorize the release of my medical records for the purpose of: _____

I do hereby authorize the release of my medical records with my signature as follows:
I authorize release of medical records and tests provided through your office. I understand that the medical information released by this authorization includes information concerning physical treatments and diagnosis and past medical history.

. I understand this authorization will expire, without express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult.

I understand that I may revoke this authorization in writing at any time.
Revocation will not apply to information that has already been released or to my insurance carrier when the law provides them with the right to contest.
I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization.

The Thayer Group for Women's Care, P.C. (David O. Thayer, MD) cannot condition treatment or payment on the signing of an authorization, except as otherwise permitted by law.
Return my records to the active file ____ Switch my records to the inactive file____

I acknowledge and accept responsibility for full payment on any outstanding balance on my bill.
I also agree to pay the charges (below) for copies made of my records to be sent to the physician above.
To have this fee waived the physician listed above must either fax a signed release from the patient to us at 303-443-7882 or call us at 303-443-2010 to request them.
$16.50 for 10 or fewer pages, $0.75 per page for pages 11-40, $0.50 per page for 41 or more.

It takes up to 5 business days for records to be released.
Please send my records via Mail _____ or by Fax _____ (only the most current can be faxed.)

INFORMATION REQUESTED:

- ☐ Copy of medical records from the Thayer Group for Women's Care, PC
- ☐ Copy of complete medical records (including previous provider records in chart)
- ☐ Copy of OB records
- ☐ Other _____