PATIENT MEDICAL RECORD RELEASE FORM

BAY ALLERGY & ASTHMA CLINIC, P.C.
RICHARD J. HORBAL, M.D. & JONATHAN M. HORBAL, D.O.
414 N. TUSCOLA ROAD
BAY CITY, MI 48708
989-895-5007 PHONE
989-895-8032 FAX

TODAY'S DATE _____

PATIENT NAME: _____ PATIENT'S DOB _____ LAST APPT:_____

MEDICAL RECORD RELEASE PERMISSION GIVEN

BY: _____ PARENT GUARDIAN PT/SELF

TYPE OF RECORDS WANTED: ☐ **ALL** ☐ **TESTING** ☐ **LAST OV** ☐ **PFT'S** ☐ **INJECTION RECORD**

OTHER_____

_____

_____

MEDICAL RECORDS TO BE RELEASED

TO: _____
(Name of Person/Organization)

_____
(Street Address)

_____
(City, State, Zip Code)

FAX NUMBER: _____

_____ Patient list above has appointment with Dr. _____ on_____ and needs medical records for this appointment.

PLEASE SEND BY: ☐ **FAX** ☐ **MAIL** ☐ **PATIENT/PARENT p/u and deliver**

Please be aware that medical records faxed or mailed by authorization of the patient and/or guardian may not be protecting patient privacy rules and regulations stated in the PHI documentation.

I, the guardian/parent/patient authorize the release of all medical records of the above named patient for future medical needs and/or medical documentation for medical care or opinion of the medical facility named above.

X _____ _____ _____
patient/legal parent or guardian **date** **initials**

_____ _____ _____
Office Staff Initials **Date faxed/mailed** **pick up fax mail**

The maximum facility fee for copying records shall be 25 cents per page, plus the actual cost of mailing the records, plus a handling fee: 0 – 30 minutes - $3.50, 31 – 60 minutes - $7.00, each additional 30 minute increment - $3.50. An itemized invoice shall accompany the copy.