

I also authorize and requests the release of the medical records for the following dependents:

Patient Name: _____ Date of Birth _____

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

Signature(Required): _____ Date(Required): _____

Name (printed): _____ Relation to patient:
 self
 legal guardian
 other

NOTICE:

Fees For Copying Medical Records

doctokr family medicine charges \$45.00/patient chart to scan your copy onto disk or to copy it to paper. For charts over 50 pages, an additional \$ 0.25/page is added to the charge.

If another medical office is releasing the records to doctokr, verify with that office what their charges will be to release the record to doctokr family medicine.

Medical records originally transferred to doctokr from other doctors are not considered part of the "release of medical records." Copies of these older records need to be obtained from previous doctors you have seen. We recommend you keep a copy of these records to avoid this inconvenience.

Requesting the release of highly sensitive information such as HIV/alcohol/psychiatric history in your record needs another authorization signatures.

I authorize the release of highly sensitive information including (state specifically what tests or records are requested):

Signature(Required): _____ Date(Required): _____