FAMILY MEDICAL CENTER

Date : _____

Patient : _____

Date of Birth : _____

Mailing Address : _____

_____

I, _____, request a copy of the medical record for the patient
(printed name of requester)
indicated above. I understand that the medical record for the patient listed above may ***ONLY*** be released to the patient, the patient's parent, or the patient's legal guardian without further written legal authorization.

I am requesting a copy of the medical record for the following reason/purpose:

_____

Please provide my medical record in the following format:

_____ Printed (I will _____pickup @ FMC or FMC to _____mail to address listed above)
I understand that the charge for this service is $25.00 for the first 1 to 20 pages and $.50 for each page thereafter if printed. I agree to pay $25.00 initially and any additional charges upon receipt of the copies. I have been informed that Family Medical Center will complete the copying process within 20 business days of my initial payment of $25.00.

_____ Diskette (I will _____pickup @ FMC or FMC to _____mail to address listed above)
I understand that the charge for this service is $25.00. I have been informed that Family Medical Center will provide a diskette within 20 business days of my initial payment of $25.00.

_____ _____
Signature of Requesting Party Date

_____
Relationship to Patient

OFFICE USE ONLY

DATE RECEIVED	:	_____	**INITIALS**	:	_____
DATE PAID	:	_____	**INITIALS**	:	_____
DATE MAILED/READY FOR PICK-UP	:	_____	**INITIALS**	:	_____