PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:____

Date of Birth: _____________________Phone Number: ______________________

Mailing Address: ____

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I request release of my medical records to

__Patient at address above

__Health care practitioner (provide name, address, phone and fax below)

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- Each chart is reviewed before copying, and the original maintained by Imershein & Birnkrant, PC, as required by law.
- At the doctor's discretion a summary of pertinent findings and tests results may replace a bulky paper copy, which will facilitate the receiving practitioner's ability to understand your medical history.
- Processing may take 30 days, unless required sooner for urgent medical need
- Records are sent by U.S. Mail, unless other arrangements are made.
- Medical Record copying & transfer fee is $50 - payable by check or credit card
- Contact the office (202-466-4800) about payment or any other questions.
- Note: This authorization expires in 120 days

Credit card # ____________________________________Visa MC Amex (circle)

Exp date _____________security code___________Billing ZipCode ___________

Patient Name (print): _______________________________

Signature___________________________________ Date___________________