MEDICAL RECORDS REQUEST FORM

Date of request:

Client Name: _____
Date of Birth: _____
Address: _____
_____
Phone number: _____

Date(s) of Treatment: _____

I, _____, am requesting a copy of my medical records. I have filled out a Release of Information form with this agency for the purpose of requesting my medical records.

I understand the agency has thirty (30) days to respond to my request.

I agree to pay 99 cents per page of medical record released to me.

_____	_____	_____
Client Name	**Client Signature**	**Date**
_____	_____	_____
Agency Witness	**Agency Witness Signature**	**Date**