# MARYCAIREMD

## RELEASE OF MEDICAL RECORDS

**Patient name** ______________________________________________

**Patient phone number** ___________________________ **Patient DOB** ________________________

**Records requested: (check all that apply)**

**___ Progress notes ___ X-rays ___ MRI or CT reports ___ Lab results ___ Complete medical record**

**I hereby authorize Mary Caire MD to:**

**_____ Release to: ______ Secure from:**

**Name** ______________________________________________

**Address** ______________________________________________

______________________________________________

**Phone** ____________________________ **Fax** _____________________________

**I understand that I may inspect or copy the protected health information to be used or disclosed. I may revoke this authorization in writing by contacting the originating office at the address above. Information used or disclosed pursuant to the authorization may be subject to re disclosure by the recipient and no longer protected by HIPAA. I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for treatment, in which case you may refuse to provide that research-related treatment).**

**This authorization shall remain in effect from the date signed below until _____________ or ___ the request has been completed. Copying fees for medical records: The fee that will be charged for all record release will be twenty five dollars ($25) for the first twenty (20) pages, and fifty cents ($0.50) per page thereafter. In addition, a reasonable fee to include actual costs for mailing, shipping, or delivery. For an execution of affidavit, fifteen dollars ($15) additional will be charged. The exception to this fee will be "transferred to another physician." By law, records will be copied and mailed 15 days from the release date providing we have the appropriate permissions to release information and fees. If records are requested sooner than 15 days, you will be charged accordingly. I hereby authorize you to disclose the specific information described above, only for the purposes and parties also described above.**

**Patient name printed** ______________________________________________

**Patient signature** ________________________________ **Date signed** _____________


4701 Old Shepard Place, Suite 260, Plano, Texas 75093

Phone: 214-383-9796 Fax: 972-943-5973 support@MaryCaireMD.com