RECORDS RELEASE MEDICAL AUTHORIZATION

Patient Name____

Address__________________________________City___________________________

State____ Zip___________ Phone_____________________ DOB__________________

Which records are needed: ____

Reason for transfer/request: ____

I, the undersigned, do hereby authorize and direct you to

◯ Furnish records ***TO*** Warner Family Practice, P.C. from:

◯ Release records ***FROM*** Warner Family Practice, P.C. to:

******IMPORTANT NOTICE: Per Warner Family Practice Policy, we only copy, print, mail or fax WFP records. We do not copy, print, mail or fax other Doctor's medical records. Please contact your past Dr. for these records.**

Name____

Address__________________________________City___________________________

State_____ Zip________ Phone_____________________ Fax ____________________

Check how records are to be received: Mail _____, Pick-Up ______, Fax _______

(If **all** records are requested, **WFP will not fax records**)

WARNER FAMILY PRACTICE, P.C.
2905 W. Warner Rd. Suite 12., Chandler, AZ 85224
Phone 480-831-8457 * Fax 480-491-3112

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that I am responsible for the cost of copies.
A copy of this authorization is as valid as an original and will expire 6 months from the date below.

Medical Records Request Fees:

- ***Print-*** I understand that you may charge me a fee of up to **$15.00** if I request my entire chart for personal use.
- ***Oversized Document-*** I understand that you may charge me a fee of up to **$25.00** if I request my entire chart for personal use and it *exceeds 100 pages*.
- ***NO CHARGE*** -Any Records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

I UNDERSTAND THAT WARNER FAMILY PRACTICE DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS.

PRINT NAME ____

SIGNATURE ___________________________ Date: _________

WITNESS ____

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