Today's Date:_____

Medical Records Release Form

Patients are now required to access the patient portal or records may be sent

Via secured fax. No paper copies can be given.

I_____D.O.B_____

am requesting Complete Family Care to release my personal records to me, or another authorized individual or company:_____

I am requesting the following records:(Please Circle What Applies)

- **My Entire Medical Record**
- **Medical Records for the following dates:_____**
- **Other Medical Testing Reports or Procedures:_____**
- **_____**

I understand that fee's may be assessed due to amount of records requested:

Fee:

Please make all checks payable to : Complete Family Care

Payment due upon request of records for records to be processed. Please allow up to thirty business days to process.

Patient Signature or Legal Guardian Signature:

_____Date:_____