By signing this form, I, D.O. B: , consent you to release confidential health information about me, by releasing a copy of my medical records and history, or a summary of my protected health information, to the physician/facility listed above.

**Purpose of request:** Personal Treatment Legal Insurance Disability Other:

**Send ones marked “X”:** OV Labs CT MRI/MRA EEG AEEG EMG

**Initial Each Line Below**

**DO** **DO** **NOT** want information on **Mental Health** to be released

**DO** **DO** **NOT** want information on **HIV Test and Related** information to be release

**DO** **DO NOT** want information about **Alcohol and/or Substance Abuse** released

**DO**   **DO NOT** want information about **Communicable Diseases** released

**Mandatory** – Please complete the check boxes above, designating the protected material, should be handled even if the categories do not necessarily relate to the medical records.

**I am requesting from this facility/provider/entity:**

Name:

Address:

Phone: Fax:

I am aware that, **for Personal Requests,** there will be a $25.00 handling fee and per page fee of $1.00 per page for pages 1-25 and $.50 per page for pages 26-350 for all requests on paper (plus cost of postage and envelope). Please be specific in the information you would like in Section 2.

**For Doctor to Doctor Requests,** there will be NO fee. By default, the past two (2) years of pertinent information will be sent.

**Patient/Representative Signature: Date:**