Thomas C. Degenhardt, M.D
Gary A. Stein, M.D
Mark E. Schakel II, M.D.
Kai-Uwe Mazur, M.D.
Frederick S. Bennett, M.D.

Michael J. McDermott, M.D.
Nathan R. Ehmer, D.O.
Dominic Mintalucci, M.D.
Christian Athanassious, M.D.
Neema Pourtaheri, M.D.

Records Request Form

----- AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION -----

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Information and records regarding treatment of minors, HIV, psychiatric mental health conditions or alcohol substance abuse have special rules that apply and require specific authorization.

Patient's Name: ____Date of Birth: ______________________________

I request and authorize ____ to release healthcare information of the above-named patient to:

Name: ____

Address: ____City: _________________________

State: ________________________________ Zip: ___________________

☐ Medical Records – Paper Copy **(25 cents per page charge for personal records. No charge if sent directly to outside physician.)**

☐ X-Ray - CD Copy **($10 per CD charge for personal records. No charge if sent directly to outside physician.)**

Yes ☐ No ☐ I authorize the release of any X-Rays, MRI's Bone Scans, etc. to the person(s) listed above.

Yes ☐ No ☐ I authorize the release of any and all records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____ Date: __________________

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as an effective and valid original document.

This authorization expires 90 days after signed.

Doctor's Initials: __________________

PLEASE FAX COMPLETED FORM TO 707-546-1897