

Spinal Care

Decompression Center

RECORD RELEASE REQUEST

I, _____, date of birth _____, hereby request a copy of:

___ My imaging reports during the time period of _____ to _____

___ My medical records, diagnosis, prognosis and recommendations as well as other data pertinent to the treatment provided to me during the time period of _____ to _____

___ The entire contents of my patient file

___ Other: _____

The above shall be released to:

___ Myself

___ The following: _____

directly from:

I agree to pay Spinal Care and Decompression Center* a flat \$5.00 fee or no more than \$.50 per page, whichever is greater (in accordance with Vermont Statute 9419), for providing copies of my health care records.

Patient Signature

Patient Name

Date of Request

Street Address

Witness

City, State, Zip

Date

*FOR OFFICE USE ONLY: Payment received by: _____ Date: _____