McDONALD

PHYSICAL THERAPY
&
SPORTS REHABILITATION CENTER

Medical Records Release Request Form

Name : _____ Date of Birth: ___/___/___
Please Print

Purpose of Release: _____

A minimum of (7) days are required to release medical records.

If a third part is involved, the following must be completed:

I grant permission for my medical records to be released to:
_____
_____
_____
_____

Description of information released:

Complete records ☐
Therapist reports ☐

Approximate dates of treatment: From_____ to _____

The following charges apply: **$15 for the first 10 pages ; $.25 for each subsequent page**

_____ _____
Signature of patient/applicant Date

COMPLETE UPON RECEIPT

Your fee for a complete copy of medical records from McDonald Physical Therapy is : $_____.

I _____ certify that I have received the requested records from McDonald Physical Therapy.

Complete Records ☐ **Therapist Reports** ☐

Patient: _____ Date: _____

Witness: _____ Date: _____