Authorization to Release Medical Records

INSTRUCTIONS: You may obtain a free copy of your medical records and billing statements by visiting the patient portal at _____ or calling _____. For all other requests, including third party requests, a fee may apply. Requests will be processed within 10-15 business days of receipt of payment. Thank you.

Patient Name: _____ Date of Birth: _____

Date(s) of Service: _____ Location(s) of Visit: _____

I, the undersigned, request that a copy of your records regarding the above-named patient's visit to a Righttime Medical Care location on the above date(s) of service be provided to:

Name:

Relationship to Patient:

Street Address:

City, State, Zip:

Contact Number:

Fax Number:

I agree that Righttime is not responsible for any action or adverse consequences related to the release of this information.

_____ _____

Signature Relationship to Patient

_____ _____

Print Name Date

Mail or fax this completed form to:

☐ I prefer to pay via credit card (you will be contacted by phone)