___ Black ___ Kosempa
___ Coran ___ Pietrocarlo
___ Guten ___ Schneider
___ Kohn ___ Zoltan

MEDICAL RECORDS RELEASE
Report / Copy Fees

___ Pick Up
___ Mail
___ Fax

PATIENT NAME ______________________________ **PHONE** (____)__________

ADDRESS ______________________ **CITY** ____________ **STATE** ___ **ZIP** ______

DATE OF BIRTH ___/___/___ **ACCT #** __________

REQUESTING:

___ Medical record copies
___ X-rays (___) original (___) copy (CD)
___ WKC or WKC16B
___ Itemized bill
___ Certification needed

TYPE OF ACCOUNT:

___ Private (not related to WC or legal)
___ Worker's comp*
___ MVA*
___ Legal matter*
*Balance on account = $__________

RELEASE SIGNED: ☐ Yes ☐ No

NEEDED: ___ ASAP By: ___/___/___

REQUESTED BY: ______________________________

____

____

MAIL TO: ______________________________

____

____

X-RAYS: Body part/extremity requested: R / L / Bil __________ # films ______

(___) X-ray copy fee $________ charge

(___) Certification fee $________ charge

(___) Report $________ charge

(___) Medical Records ____ pages $________ charge

(___) Sales tax $________ charge

(___) Mailing fee $________ charge

TOTAL DUE: $__________

PRE-PAY

☐ **YES**

☐ **NO**

* *

PATIENT SIGNATURE ______________________________ DATE ___/___/___

PHYSICIAN APPROVAL ______________________________ DATE ___/___/___

INITIALS ______ COPIED ___/___/___ BILLED ___/___/___ MAILED ___/___/___