

FAMILY PRACTICE ASSOCIATES, P.C.

Pamela Abrams, MD ♦ Brad Anderson, MD ♦ Laura Bland, PA-C ♦ Shannon Christopher, NP
433 Summit Blvd, #201 ♦ Broomfield, CO 80021 ♦ Phone: 303-673-9090 ♦ Fax: 303-673-9195

Request for Release of Medical Records From FPA

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Date of Request: _____ (Please allow up to 1 week for copying records.)

I hereby request that my medical records be released for dates of service from _____ to _____
with the exception of:

Progress Notes Psychological or Psychiatric Conditions
 Drug or Alcohol Abuse STDs / Communicable Diseases Other _____

I understand this information will be used for: _____

Please send records to: Practice Name and/or Provider Name: _____

Address: _____

City / State / Zip: _____

Phone: _____ Fax: _____

We are happy to send medical records to a Medical Facility or Physician's Office for **NO CHARGE**. If patients are requesting medical records for personal use, our fees are as follows (please choose one):

- \$0 – Less than 10 pages of medical records to be picked up
- \$5 - Less than 10 pages of medical records to be mailed
- \$15 – Last 3 years of records to be picked up
- \$20 – Last 3 years of records to be mailed
- \$25 – More than 3 years and/or entire chart to be picked up
- \$30 – More than 3 years and/or entire chart to be mailed

Please enclose check payable to Family Practice Associates OR charge to a credit card:

Name on card: _____ Billing Address: _____

Card #: _____ Expiration: _____ Security Code: _____

SIGNATURE: _____ **DATE:** _____

Date Mailed / Picked-Up: _____	Signature: _____
Type of ID presented: _____	Daytime Phone: _____