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)