CRYSTAL CANYON EAR, NOSE, THROAT & FACIAL PLASTIC SURGERY
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RELEASE OF MEDICAL RECORDS

As required by the "Notice of Protected Health Information"

Patient's Name _____
Date of Birth _____

Requesting my medical records:

FROM: Crystal Canyon ENT & FPS
1340 N. Rim Dr.
Flagstaff, AZ 86001

TO: *Name of facility or Doctor* _____
Address _____
Phone number _____
Fax number _____

Request for Access: (check one)

__ Send my medical records relating to the following treatment(s) or condition(s):
_____

__ Send my medical records for the following dates:
_____

__ Send ALL my medical records

Type of access requested: (check one)

__ Inspection only (*I agree not to make any marks on or alter the record in any way and understand that an office representative will be present*)

__ Copies of my medical records (*I agree to pay in advance for the cost of copying, mailing, labor and supplies in processing this request as discussed below*)

Charges:

__ I understand and agree that this office may charge me a minimum of $15.00 and a maximum of $30.00 for copies of my medical records. This fee includes reasonable personnel costs in making the records available and the actual cost of duplicating, etc. There is NO CHARGE when sending records to another medical facility.

_____ _____
Patient or Legal Guardian Signature Date