



I (we) further agree that the Practice may charge me or any designated recipients the actual cost incurred in preparing the copy of the requested Medical Records.

SIGNATURE _____ DATE _____
ADDRESS _____ PHONE _____

INDICATE PERSON SIGNING BY CHECKING APPROPRIATELY BELOW:

____ Patient ____ Parent/Guardian of minor patient ____ Guardian of incompetent patient
Deceased patient's: ____ Personal Representative; if none, ____ Spouse; if none ____ Any Child

It is understood that the foregoing is confidential information and will be considered as such. Furthermore, Kendrick Regional Center for Colon & Rectal Care is hereby released from any legal liability that might arise from release of such information.

Patient Name (Print)

Social Security #

Patient Signature/Authorized Guardian

Date

Witness

Date