Dr. Jodi Berg
Integrative Family Health Clinic

Medical Records Release Acknowledgment & Consent

I, _____, voluntarily request a copy of my medical records from Integrative Family Health Clinic.

I understand that my medical records contain confidential, sensitive, and personal health information. I acknowledge that I have been informed that I am not required by the clinic to provide these records to my employer or any other third party. I understand that any decision to share my medical records is entirely my own. I understand that once my medical records have been released to me, whether by secure email or in-person pickup, Integrative Family Health Clinic is not responsible for how the records are used, stored, shared, or disclosed by me or any third party. I accept responsibility for any voluntary disclosure of my medical records after they have been released to me.

For requests related to FMLA, disability, workers' compensation, employer accommodations, insurance claims, or other third-party benefit or leave programs, I understand that copies of both the completed paperwork and my medical records will not be released to me until the required paperwork has been completed by Integrative Family Health Clinic, submitted to the requesting third party (when applicable), and confirmation of receipt has been received by the clinic.

I acknowledge that I have had the opportunity to ask questions regarding my request and that I am requesting the release of my medical records voluntarily.

Copying Fees: I understand and agree to the following fee copies of my medical records:
• 1–30 pages: **$1.17 per page**
• Over 30 pages: **$0.26 per page**

Method of Release: ☐ In Person ☐ Secure Email

Email Address (if applicable): _____

I have read, understood, and agree to the terms of this Medical Records Release Acknowledgment and Consent.

Patient's DOB: _____

Patient Signature: _____ **Date:** _____

Clinic Staff Witness: _____ **Date:** _____