

Release of Medical Information (Medical Records Request)

Completed form can faxed to Palma Ceia Family Care (801) 701-8682 or emailed to support@pcfamilycare.com

I hereby request medical records including as marked below.

_____ Doctor and health care provider notes including H&P and discharge summaries.

_____ Vaccine records.

_____ Lab reports.

_____ Diagnostic imaging reports.

Patient's Legal First Name & Last Name _____

Date of Birth) _____

Patient's Signature _____ Date: _____

Please send records to the following entity/person

_____ Fax Number: _____

_____ Email: _____

_____ Mailing Address: _____

Please note that mailed records will be charged the following fees and must be paid in full prior to the records being shipped. There is no charge for email or faxing.

Postage Rates

- Applicable Postage Fees
- For the first 25 pages, the cost shall be \$1.00 per page.
- For each page in excess of 25 pages, the cost shall be \$0.25.