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INTERNAL MEDICINE
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RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I, as a patient of Dr. Boston, authorize Dr. Boston's office to release the following records to myself:

Treatment Dates (please be specific): _____

_____All Records
_____Discharge Summary
_____X-Ray/Radiology Reports
_____Consultation Report
_____Medication List
_____Single Chart Note/Report
_____History and Physical
_____Lab Reports
_____Emergency Room Reports
_____Pathology Reports
_____Mental Health
_____Other: _____

Exclusions:

_____

I request the records to be (choose one) _____ Paper Copies or _____ CD

Signature: _____ Date: _____

FOR THOSE THAT HAVE REQUESTED THEIR WHOLE MEDICAL RECORD:

I have received a copy of my medical records and understand that the first copy is free and each additional copy is $50.00.

Signature: _____ Date: _____