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REQUEST FOR RELEASE OF MEDICAL RECORDS FORM

To obtain a copy of your medical record or transfer it to another physician, please fill out and sign this form then return it to the office address above.
Please call the office if you have any questions.

Your completion of this form means that you authorize the release of all or specified necessary medical records from Cassandra Ohlsen, M.D., Inc.

I hereby request the transfer of medical records for patient:

Name:_____
Date of birth:_____
Address:_____
Phone number:_____

Records to be transferred (please specify or mark with a check):

` All necessary records
` All records form dates of service (ex. last 3 years):_____
` Specified portions of records:_____
_____
` Progress notes` Labs` Imaging` EKG` Other (list above)

Please transfer these records to (health care provider or patient):

Name:_____
Address:_____
Phone number:_____
Email(optional):_____

Check the below box only if you agree and consent to the following:

Your health information will be sent via standard unencrypted email to the above email address. Please ensure the recipient's email address is accurate. Once sent, the email cannot be recovered or canceled. By checking the agreement box and providing the above email address, you understand and acknowledge that you are solely responsible for the confidentiality and security of the information you consent to transmit out of our secure network.

*_____ *_____
Signature patient or legal conservator **Date**

*Records are only sent if this form is filled out and a valid signature is included.