# Medical Records Request Form / Release

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

DOB: _____

SSN: _____

Email: _____

Credit Card: _____

Exp: _____ CVV: _____

I am the patient listed above or a legally authorized representative (with proof enclosed) requesting my entire medical record. I understand that the state of Michigan allows reasonable fees to be charged for this service. John Crisler DO PLLC charges $1.00 per page for pages 1-20, $0.50 per page for pages 21-50, and $0.20 per page for pages 51+. If provided by email, there are no additional transmission charges. Records and receipts are automatically provided via email unless you request otherwise or have no email address. If provided by postal mail or fax, additional postage or access fees may be applicable. By submitting this request you authorize the applicable charge to the credit card provided above.

I understand that this authorization allows my medical record to be released to:

____ MYSELF ONLY

____ ANOTHER PARTY: Name: _____

Address: _____

City, St, Zip: _____

Email: _____

Please note that once we begin processing your request we will calculate the fee due, charge your credit card, and process your request within a reasonable time, usually within 30 days.

Signature: _____ Date: _____