Terren D. Klein M.D., P.A.
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Release of Information

Patient's Last Name	Patient's First Name	Patient's DOB	MRN

Description of medical records being requested:

- ***All*** medical records are being requested from the office Dr. Terren D. Klein M.D.,P.A.
- Requesting All medical records from the office of Dr. _____ to be sent to the office of Dr. Terren D. Klein M.D., P.A.
- Medical records being requested from the office of Dr. Terren D. Klein M.D.,P.A. are specified by the following dates of service:

  _____

- Requesting medical records to be sent to the office of:

  Doctors Name:
  Address:
  Phone Number:
  Fax Number:

- I am requesting my medical records for personal use and filing and can be sent to the listed address:

  Patient Name:
  Address:
  Phone Number:

- Medical records may include, but are not limited to: Patient demographics, History and Physical, Progress notes (OV notes), Consultation(s), Pre and Post-Operative/Procedure notes, Work status notes, Lab results, Imaging/ Diagnostic results
- I understand that upon a requisition of retrieving my personal medical records, from the office of Dr. Terren D. Klein M.D.,P.A., for personal use I will be charged a fee of up to $25.00 for the initial 20 pages of my personal record and an additional $0.50 fee for any additional pages
- Due to the high frequency request our office receives for medical records please be advised that a compilement of a medical record may take anywhere from **7-10 business days** with the exclusions of holiday's and office closures
- I do understand, as a patient here within the office of Dr. Terren D. Klein M.D,P.A., this form follows the HIPPA compliancy act. I do understand and authorize, the office of Dr. Terren D. Klein M.D.,P.A. and staff, to release all medical records here within the practice to the location specified within this form

Printed Name: _____ Patient Signature: _____

Date: _____