

PMSI Medical Records  
PO Box 1155  
Pottstown, PA 19464  
Phone – 484-945-0610  
Fax – 484-945-0615  
Medicalrecords@pmsiforlife.com

**Authorization to Release Medical Records**

I authorize \_\_\_\_\_ (practice or doctors' name) to release **all** of my medical records, including test results, visit notes, correspondence, mental health records, HIV records, etc. I release PMSI from any laws related to disclosure of confidential and privileged information.

**Optional: Exclude the following records:** \_\_\_\_\_

\_\_\_ **Option #1:** Your medical records on a disc. The cost will be determined by the size of your file. The charges are either \$15.86, \$21.11 or \$26.36. You will be invoiced for the cost.

\_\_\_ **Option #2:** To receive a paper copy of your chart, the charge will follow the fee schedule set forth by the State of Pennsylvania:  
Pages 1-20 at \$1.55 per page; Pages 21-60 at \$1.15 per page; Pages 61+ at \$0.39 per page.

\_\_\_ **Option #3:** You may join PMSI's patient portal, Follow My Health and print your own records at no cost. Please provide your email below and an invitation to join will be emailed to you.

**Payments must be received prior to records being prepared.**

For paper copies, an estimate will be provided. Please complete this form in it's entirety to avoid delays.

**Please make checks payable to: Pottstown Medical Specialists, Inc.**

RECORDS PERTAINING TO:

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ (if joining Follow My Health only)

**Reason for request:** \_\_\_\_\_

**Records will be mailed to the patient upon receipt of payment.** Records cannot be faxed.

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not the Patient or Parent, relationship to Patient: \_\_\_\_\_

**Request valid for 90 days**