

**FAMILY PLANNING ASSOCIATES MEDICAL GROUP, LTD**  
Request for Patient Access to Medical Records—Records Release

I, \_\_\_\_\_, (requestor) hereby authorize and request Family Planning  
(Print first and last name)  
Associates Medical Group, to release a copy of any and all medical records relating to the services  
and/or treatment I received on \_\_\_\_\_ at \_\_\_\_\_.  
(Date) (FPA Location)

**I was seen for the following type of services:**

- Surgical Abortion
- Medication Abortion (The Abortion Pill)
- Sonogram
- Gynecological Exam and/or Testing
- Other: \_\_\_\_\_

**My method of payment was:**

- Cash
- Insurance

**Please select one of the following options:**

- I would like to pick up my medical records. When they are ready I can be reached at:

\_\_\_\_\_  
(Telephone Number)

- My medical records are to be sent by mail or fax to the following location:

\_\_\_\_\_  
(Doctor/Hospital, if applicable)

\_\_\_\_\_  
(Street Address, City, State, and Zip Code)

\_\_\_\_\_  
(Phone Number and Fax Number)

This authorization shall be effective until \_\_\_\_\_. I acknowledge that the fee for providing these records is \_\_\_\_\_, which I agree to pay. Please note that a \$25.00 service fee will be applied for inspection, retrieval and copying for medical records. This fee is waived when records are being transferred to another healthcare facility. **Please note that photo identification is required, without exception.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (City, State and Zip Code)

Telephone Contact: \_\_\_\_\_  
(Primary Number) (Alternative Number)

If not signed by the patient, please indicate the relationship: \_\_\_\_\_