Altus Cancer Center
310 North 11th St
Beaumont, Texas 77702
409.981.5510 Fax: 409.981.5511

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ______________________________________ **Patient I.D:** __________________________

Date of Birth: ___/____/_____ **SSN:** _______________________________

I request and authorize Altus Cancer Center to release or retrieve a complete copy of my medical records to or from:

Facility: ____

Address: ____

City: ______________________________ **State:** _____________**Zip:** ___________________

Phone:____________________________ **Fax:** ____________________________________

This request and authorization applies to:

Film(s) or CD **Complete Medical Records**

Report (MRI, CT, OR, NUC, PET CT)

Relating to the following studies and dates:

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Patient's Signature: **Printed Name:** **Date Signed:**

________________________________ _____________________________ ______________________

Charges:

Medical Records: $8.00 of films/CD for Imaging/ $ 32.50 for Complete Medical Records.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.