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PLANTATION, FL 33324
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RELEASE OF RECORDS / REQUEST FOR COPIES

Please mark the appropriate line below and sign.

_____ I request a copy of my records be provided to me. I understand that I will pay a copying charge of \$1.00 per page at the time I pick up my records.

_____ I request a copy of my x-rays be provided to me. I understand that I will pay a copying charge of \$25.00 - \$53.00 per sheet of film at the time I pick up my films. The original film itself is the property of this office.

These copying charges must be paid at the time the records are picked up. These charges cannot be added to any existing account with this office or billed to any other entity. I understand that if I request the records but fail to pick them up, I will still be charged for the copies.

Patient Name Printed Date of Request

Social Security Number Date of Birth

Patient's Signature Authorized Staff Person

Date records/films will be available for pick up

Personal Representative Name Printed Yes _____ No
ID Verified (Copy Made)

Personal Representative Signature Date Picked Up