BEE CAVES FAMILY PRACTICE

MEDICAL RECORD RELEASE FORM

Patient Information

Patient Full Name:_____ Date of Birth: _____
Patient Address: _____Home Phone: _____
City: _____State: _____Zip: _____ Work Phone: _____

Release Information To:

I hereby Authorize BCFP or Complete Medical Management to release my medical record information to:

(Choose 1 Location Only) ____Mail Copies To: ____Fax To: ____Email_____

To:
Name/Facility:_____Attention:_____
Address: _____Phone: _____
City: _____State: ____Zip: _____Fax: _____
Email:_____

Payment information:

$25 fee up to 500 pages per digital chart ($50 for 500+ pages) plus postage or

$25 for the first 20 pages and .50 per page thereafter for paper chart plus postage.

Check /Visa/ Mastercard/American Express accepted Circle one: Visa or Mastercard or AMEX Credit Card # _____ Exp. Date_____ CVV: _____

Name on Card: _____

Cardholders Mailing Address: _____
City: _____State: _____Zip: _____

Contact Information

Complete Medical Management (CMM)
Phone: 512-288-2011 ext 203
Fax Request to: 512-870-9502
Email Request to: request@completemm.com

Mail Request to:
CMM
P.O. Box 150841
Austin, Texas 78715

Patient Signature Print Name Date _____

Parent/Guardian Signature Print Name Date_____