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RECORDS RELEASE

Please fill out this form completely.

Date needed by: _____

Today's Date: _____

(THIS FORM WILL EXPIRE ONE YEAR FROM THE ABOVE DATE)

Name of Patient (please print full name): _____

Alias: _____

Patient's complete address: _____

Patient's date of birth: _____

Name of person requesting records transfer: *(please print full name)* _____

Relationship to patient: _____

Phone number where you can be reached for questions: _____

The records will be **SENT FROM:**

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax (optional): _____

The records will be **SENT TO:**

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax (optional): _____

What information do you want sent? Please check the appropriate boxes.

- ❑ Dictation / Notes
- ❑ OP Reports
- ❑ Radiology / Reports
- ❑ Labs
- ❑ Audio
- ❑ Med lists
- ❑ Allergy Tests
- ❑ Dates: _____
- ❑ Consults
- ❑ Other: _____

Information will be disclosed because of:

- ❑ Personal reasons
- ❑ Legal issues
- ❑ Transferring care
- ❑ Other: _____

My signature is approval of my authorization. I authorize the above named Medical Practice/provider to release my protected health information to those identified on this release. I understand that if any person receives this information that is not covered by the federal privacy regulation, the release may no longer be protected.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I may revoke this release at any time by a written notification unless action has previously been taken or for obtaining insurance coverage.

Signature of Patient : _____ Date: _____

(if minor under age of 18, guardian's signature)