Medical Records Request

Patient Name: _____ **DOB**: _____ **Phone:** _____

Mailing Address: _____ **Email**: _____

Description of information to be disclosed – I authorize the practice to disclose any and all of parts my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ('HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, (except for psychotherapy notes) chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I also understand a copy of this authorization is as valid as the original and the provider may not condition treatment by my decision to sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations. My provider cannot withhold treatment if I do not sign this form. A copy of this form is as valid as the original.

Information to be disclosed (please select one): ____ Entire patient record **OR** Treatment date(s): From: _____To: _____

If **billing** is requested, please check here: _____

Purpose of Disclosure: At the request of the individual

(FROM) The following organization is authorized to **disclose** the information:

Individual/Entity Name: _____

Address: _____

Phone: _____ **Fax**: _____ **Email:** _____

**I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below.

(TO) Who will be authorized to **receive** information:

Individual/Entity Name: _____

Address: _____

Phone: _____ **Fax**: _____ **Email:** _____

***Note: Some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate fax or email as your preferred method if this is a concern to you. This authorization will expire in 12 months from the date of this authorization unless otherwise specified by you. You have the right to revoke this authorization at any time by submitting a written request to the practice. Revocation will be effective upon received written notice. We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. It is understood a fee may apply for obtaining records.*

Signature of patient: _____**Date**: _____

If you are not the patient:

*What is your relationship to the patient? _____

*If you are the patient's healthcare decision maker, please provide a **Medical Power of Attorney.**

*If the patient deceased and you are the personal representative of the patient's estate, please attach evidence (e.g. Death Certificate)