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MEDICAL RECORDS RELEASE

FULL NAME (Last, First, Middle Initial) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____ **TODAY'S DATE** (MM/DD/YYYY) _____

MAILING ADDRESS (Street, City, State, and Zip Code) _____

HOME TELEPHONE NUMBER _____ **BUSINESS TELEPHONE NUMBER** _____ **CELL # OR PREFERRED CONTACT NUMBER** _____

REASON YOU ARE REQUESTING A TRANSFER OF YOUR RECORDS TO ANOTHER PROVIDER? _____

PLEASE OBTAIN INFORMATION FROM:

NAME OF PROVIDER OR ORGANIZATION: _____

ADDRESS: _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

PLEASE SEND MEDICAL RECORDS TO:

NAME OF PROVIDER OR ORGANIZATION: _____

ADDRESS: _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

All records from the previous 3 years will be sent unless otherwise requested. I authorize the following information to be released:
(Please initial all that apply)

___ Pathology Reports
___ Urine Cultures
___ Medical Records
___ Ultrasound Reports
___ Requesting records from _____ to _____
___ Pap Smears
___ Blood Work
___ Office Notes
___
___ Mammogram Reports
___ Operative Reports
___ Infertility Notes
___ Bone Density
___ Other

Please **Do Not** send the following records:
___ HIV Test Results
___ Drug/Alcohol Assessment/Treatment
___ Other: _____
___ Records related to Admission & Treatment for the following Medical Condition or Injury.

EXPIRATION of this Authorization expires 60 days unless otherwise notes. A duplicate of this authorization shall be valid for all purposes. This Authorization is subject to revocation at any time. This Information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no disclosure for this information without Specific, Written, & Informed release of the individual to whom it pertains, or is otherwise permitted by State Law. A General Authorization for the release of Medical or other information is not sufficient for the purpose of release of HIV Test Results or Diagnosis. We encourage patients to personally pick up copies of their medical records. Medical Records will be sent via Certified US Mail and there will be a charge for this service, unless the medical record being sent is for continuity of care and is a direct referral from our practice.

Patient Signature _____ **Today's Date (MM/DD/YYYY)** _____

Physician Authorization _____ **Today's Date (MM/DD/YYYY)** _____