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MEDICAL RECORDS RELEASE

RECORDS FROM:

_____
Name

_____
Phone & Fax Number

RECORDS TO BE REALEASED TO:

_____
Name

_____
Phone & Fax Number

Patient's Name: _____SSN# & DOB: _____

By signing this form I authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____ALL MEDICAL RECORDS (for continued care)

_____Medical Records _____Billing Records _____Records of care from _____ to _____only
_____Records of care concerning the following condition(s)_____
_____Confer with other person orally about information in my medical record
_____HIV/AIDS. I consent to the release of any positive or negative rest result of AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.Initial_____ Date_____

The reason(s) or purpose(s) for this release of information are:

_____

I understand the information released is for the specific reason(s) or purpose(s) stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire ninety (90) days after the date of my signature unless otherwise specified in writing.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
The practice will not condition my treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that you will provide this information within fifteen (15) business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

If applicable, I understand the fee is waived because the records are to be used for supporting and application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

_____
Signed (Patient or person legally authorized to consent on patient's behalf)

_____
Date