COMPLETE FAMILY CARE

REQUEST FOR MEDICAL RECORDS-RELEASE FORM

Patient Name:_____ DOB:_____

Phone:_____

The patient listed above authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ Facility Phone:_____

Facility Address:_____ Facility Fax:_____

Dates and type of information to disclose:

☐ All Medical records
☐ Lab/ Diagnostic Results
☐ Radiology Results
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA med Ctr)
☐ Referral
☐Other_____
_____

RESTRICTIONS: Only Medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

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.

This information may be disclosed and used by the following individual or organizations:

Release to:_____

Address:_____Apt_____City_____State_____Zip_____

Fax:_____ Phone:_____ ☐ **Please mail records.** ☐ **Please fax records**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of Authorized Representative