

# REQUEST FOR RELEASE OF MEDICAL RECORDS

**SECTION 1 I hereby request the release of the medical records of:**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Patient DOB: \_\_\_/\_\_\_/\_\_\_ Previous name(s): \_\_\_\_\_  
Home address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
E-mail address (optional): \_\_\_\_\_ Medical Record/patient ID number (optional): \_\_\_\_\_

**SECTION 2 To be retrieved from the clinic below:**

Physician name: \_\_\_\_\_  
Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Information needed by: \_\_\_/\_\_\_/\_\_\_ (optional)

**SECTION 3 And delivered to the clinic/person below:**

Physician name: \_\_\_\_\_  
Clinic: \_\_\_\_\_  
And/or person: First name: \_\_\_\_\_  
Last name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**SECTION 4 Information to be released (IMPORTANT: indicate only the information that you are authorizing to be released)**

Specific dates/years of treatment: \_\_\_\_\_

All health information

**OR** to only release specific portions of your health information, indicate the categories to be released:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> History/Physical                         | <input type="checkbox"/> Mental Health     | <input type="checkbox"/> Immunizations                     |
| <input type="checkbox"/> Laboratory Report                        | <input type="checkbox"/> Care Plan         | <input type="checkbox"/> HIV/AIDS testing                  |
| <input type="checkbox"/> Emergency Room Report                    | <input type="checkbox"/> Billing records   | <input type="checkbox"/> Radiology Report                  |
| <input type="checkbox"/> Surgical Report                          | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Image(s)                |
| <input type="checkbox"/> Medications                              | <input type="checkbox"/> Progress Notes    | <input type="checkbox"/> Photos/video/digital/other images |
| <input type="checkbox"/> Other information or instructions: _____ |  |  |

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

- Chemical dependency program       Psychotherapy notes

**SECTION 5 Reason(s) for releasing information**

- |  |   |
|--|---|
| <input type="checkbox"/> Patient's request             | <input type="checkbox"/> Legal  |
| <input type="checkbox"/> Review patient's current care | <input type="checkbox"/> Appeal denial of Social Security Disability income or benefits                       |
| <input type="checkbox"/> Treatment/continued care      | <input type="checkbox"/> Marketing purposes (payment or compensation involved? Circle: NO YES, amount: _____) |
| <input type="checkbox"/> Payment                       | <input type="checkbox"/> Other (please explain): _____  |
| <input type="checkbox"/> Insurance application         |   |

**SECTION 6 Health information includes written and oral information.** By indicating any of the categories in section 4, you are giving permission for written information to be released and for a person in section 2 to talk to a person in section 3 about your health information. If you do not want to give your permission for a person in section 2 to talk to a person in section 3 about your health information, initial or check here: \_\_\_\_\_

**SECTION 7 I understand that** by signing this form, I am requesting that the health information specified in Section 4 be sent to the third party named in Section 3 above. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 2. If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified in Section 4 is sent to the third party named in Section 3 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization named in Section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care. I understand the party listed in section 2 legally has **30 days to produce document(s)** requested in section 4.

*This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: Date: \_\_\_/\_\_\_/\_\_\_*

or specific event: \_\_\_\_\_

**SECTION 8** Patient's signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

OR legally authorized representative's signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Printed Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Please note we will require a **copy of your photo ID** along with this completed form.

Photo ID copied by (staff signature): \_\_\_\_\_