REQUEST FOR RECORDS

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year last seen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for request of records:

\_\_\_Transferring to another physician or 2nd opinion \_\_Personal use (own records, lawyer, insurance, etc)

This request and authorization applies to:

\_\_\_\_All health care information \_\_\_\_X-rays only \_\_\_\_Chart notes only

\_\_\_\_Chart notes/x-rays relating to certain dates/problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A patient’s express consent is required to release any health care information relating to testing,

diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted disease, psychotherapy notes, or

drug and/or alcohol use. Please circle the “include” or “exclude” for each of the following:

Include Exclude My health information related to drug abuse, if any,

Include Exclude My health information related to alcohol abuse, if any,

Include Exclude My health information related to HIV/AIDS or sexually transmitted diseases, if any,

Include Exclude My health information related to psychological/psychiatric conditions, including psychotherapy notes, if any.

I understand that:

* I may inspect or copy the protected health information to be used or disclosed.
* I may revoke this authorization in writing by contacting your office at the above address.
* Information used or disclosed pursuant to the authorization may be subject to redisclose by the recipient and no longer be protected by HIPPA

Records to be disclosed FROM: Records to be disclosed TO:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize you to use or disclose the specific information described above, only for the purposes and parties above.

Patient or legal guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_