Medical Records Release

Clinic Stamp

Primary Health Medical Group

Patient Name _____ **Date of Birth** _____

Previous Name _____ **Daytime Phone** _____

Please check one:

I request and authorize PHMG to: ☐ Release To ☐ Obtain From

Name: Phone:

Address: Fax:

City: State: Zip:

You may use or disclose the following health care information (check all that apply):

Patients who request more than the last 2 years of their records may be charged a $10 service fee. All payments are required prior to copying. All records are burned to a CD, faxed or e-mailed. If paper copies are requested, there will be additional charges.

☐ Chart Notes ☐ Patient Visit Summary ☐ All Records

☐ Labs / Pathology ☐ Most Recent Specialist(s) Visit ☐ Billing

☐ X-rays / Diagnostics ☐ Last Well Child Check

☐ Immunizations ☐ Growth Chart

Other: Time Frame Requested:

Pick up: Where: Faxed: Mailed: Emailed:

Email address:

Reason for Authorization: ☐ At the request of the individual ☐ Other:

Expiration: ☐ Date: ☐ OR ☐ Event (one time release):

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized PHMG to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original.
I understand that I may revoke this authorization in writing at any time to PHMG, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked NO and initialed it.

☐ Yes ☐ No Initials

Date _____

Signature/Legally Responsible Party Relationship to Patient