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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: H) _____ Phone: C) _____
Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

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

To:
Facility Name: _____
Facility Address: _____
City, ST, Zip: _____
Phone/Fax: _____

From:
Facility Name: _____
Facility Address: _____
City, ST, Zip: _____
Phone/Fax: _____

Specific information to be released:

☐ GYN/ PAP Records (past___ years) ☐ Labs/X-ray Reports (date___) ☐ Immunization/ Pediatric Records
☐ Neurodiagnostic testing (date___) ☐ Medications ☐ ER Reports (date___)
☐ Last 3 visits ☐ Drug/Alcohol/STD/HIV/Mental Health Info**
☐ Other _____

The purpose of disclosure is:

☐ Ongoing Medical Treatment ☐ Insurance Request
☐ Personal Legal/Admin ☐ 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.

I understand I may revoke this authorization at any time. I must do so in writing and present my written revocation to the office. 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 not 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 one year from date signed.**
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 it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact All Seasons Family Health Care.

Fee for coping records

Personal Request: No charge for a one time courtesy copy of current records up to 25 pages
Insurance/Admin: First 50 pages $50.00, each additional page $.50.
Provider Request: No charge for copies of records required for specified ongoing care Requests for copies of all records without regard to specific illness or time frame first 25 pages $25.00
Legal Request: First 50 Pages $65.00, each additional page $.60.

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