

# Request for Release of Medical Health Information/Records

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

***Please Check Type of Information to be Released:***

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Diagnostic studies/reports	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Laboratory Test Results	<input type="checkbox"/> diagnostic Imaging Reports	<input type="checkbox"/> X-ray, films, images*
<input type="checkbox"/> Photographs, Videotapes, CD-Rom	<input type="checkbox"/> Complete Billing Record	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> Other (please specify) _____		

Covering the Dates of: \_\_\_\_\_

***Purpose for Release of Medical Records:***

<input type="checkbox"/> Further Medical Care	<input type="checkbox"/> Personal (at the request of patient)	<input type="checkbox"/> Changing Physician
<input type="checkbox"/> Legal Action or Investigation	<input type="checkbox"/> Insurance Eligibility/Benefits	
<input type="checkbox"/> Other (please specify) _____		

I understand that if the person and/or organization listed above is not in the health care industry, who are bound by Federal Privacy Standards, the health information released as a result of the authorization may no longer be protected by the Federal Privacy Standards allowing the possible release of my medical information without my authorization.

***(check box)***

***By completing this request, I authorize***

Name of Health Provider \_\_\_\_\_ **to Release my Protected Health Information to me and to deliver it to me via my secure patient portal account.**

\*Actual films cannot be delivered electronically and will be sent to the patient or may be picked up in the office within 48 hours of request.