Medical Record Release

Patient Name: ________________________________**DOB:** ____/____/______ **SS #:** ______/_____/_____

Address: ____________________________________ **St:** __________ **Zip Code:** ______________________

Requested By

□**Company:** __________________________ □**Individual:**__________________ **Date:** ____/_____/____

Address: ____________________________________ **St:** ___________ **Zip Code:** _____________________

Phone: ____/____/_____ **E-mail:** __________________@_________________

Information Requested

□**All Dates of Service** □**Specific Date of Service:** ___/___/___ to ___/___/_____

□Entire Medical Record □History/ Physical □Progress Notes □EKG Reports
□Laboratory Reports □Radiology Reports □Discharge Summary □Accounting/Billing
□HIV Testing □Chemical Dependency □Other _______________,________________

Required Authorization

□**Patient Authorization is not required.** Use and disclosure of PHI is permitted per HIPAA Notice of Privacy Practices.

□**Patient Authorization is required.**

□**I give my specific authorization** for the company to disclose my medical record to the above requestor. This authorization is valid for 180 days from the date signed and may be revoked at any time.

Signature: ____ **Date:** ___/___/____

(Patient or Patient Representative)

Internal Use

□ **The Company has accepted** the medical record request. Copies have been sent via □Mail □Fax □E-mail □Other__
□**The Company is unable to comply** with your request at this time for the specified reasons. __________________

____.

□This form has been filed in the Medical Record Department

Signature: ____ Date: ______/______/______

(Company Medical Record Representative)