PATIENT REQUEST FOR RECORDS

Authorization for Release of Protected Health Information (PHI)

*Required

*Name of Patient: _____ *Soc. Security #: _____

*Address: _____ *Phone Number: _____

_____ *Date of Birth: ____/____/____

Email Address: _____ Medical Record # _____

1. Type of Request: I hereby request that _____ provide the following health records.

_____

(Name and Address of Hospital or Physician)

2. Reason for Release: □ **Personal Copy** □ **Transfer to New Doctor** □ **Move** □ **Attorney/Legal** □ **Insurance**

3. *Select delivery method: □ **Pick up in Person** □ **Certified Overnight delivery (extra charge)** □ **US Mail** □ **eRelease** (method)_____

4. Date Range of Health Records to be Released _____

5. *Description of Records to be Released: (Check ALL that apply)

☐ Entire Medical Record	☐ Consultation Notes	☐ Operative Reports	☐ Billing Records
☐ ER Record	☐ History and Physical	☐ X-Rays Reports	☐ All Records
☐ Outpatient Record	☐ Pathology Reports	☐ EKG/EEG	☐ All Signed Consents
☐ Discharge Summary	☐ Progress Notes	☐ Lab Reports	☐ Other (Specify)_____

6. Specific Confidential PHI Authorized for This Release:

I am authorizing _____**(hospital or physician)** to release the indicated type of information pursuant to this Authorization from the treatment date(s) listed above.

☐ HIV/AID Related Information	☐ Drug and Alcohol Information	☐ Genetic Information
☐ Mental Health & Psychotherapy Information	☐ Sexually Transmitted Disease Information	☐ Tuberculosis Information

7. *Release PHI To:

☐ Patient (Same as Above) ☐ Parent / Guardian ☐ Organization/Insurance/Lawyer, etc.

* Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

E-mail: _____ E-mail: _____

Fees: I understand I may incur a reasonable, cost-based fee where applicable for copying (state maximum fees vary), postage, preparation and labor. ____ I agree to pay all charges. ____ Please contact me with estimated full cost before proceeding.

This signed Authorization will expire in one year unless an earlier date is indicated. Alternate date:

I understand that I may revoke this authorization by sending a letter to _____(Name of Healthcare Provider) at the address listed above.

I have read and signed this authorization.

_____ _____ _____

*Signature *Date *Relationship to Patient

Please see section 164.524 of HIPAA: Access of individuals to protected health information.
Can be viewed at http://patientprivacyrights.org/wp-content/uploads/2010/06/164-524.pdf