Acute Family Medicine Clinic

acutefamilymedicine.com

AUTHORIZATION TO: RELEASE / OBTAIN MEDICAL RECORDS

Patient Name___________________________________ Date of Birth____________________

I, ____ authorize Dr.____________________
And/or Staff of: ____
Address: ____
Phone: _______________________________________ Fax: ___________________________

To release my medical records to:

Name: ____
Address: ____
Phone: _______________________________________ Fax: ___________________________

Information requested for the following purpose: ☐ Patient Treatment ☐ Payment/Billing ☐ Healthcare Operation

By initialing the spaces below, I specifically authorize to release/obtain the following medical records, if such records exist:
___ Entire medical record (all information)
___ Other. Please state what part(s) are to be released: ____________________________________
____

The following items **MUST** be initialed to be included in the use or disclosure of other records:

___ HIV/AIDS related records (must be initialed to be included in other documents)
___ Drug/alcohol diagnosis, treatment or referral information is to be disclosed." Please provide a specific description: ____
___ Psychotherapy notes. (If this authorization is for the use and /or disclosure of psychotherapy notes, it cannot be combined with any other authorization).

- I understand this authorization may be revoked at any time by giving written notice to AFMC. The only exception is when action has been taken in reliance on the authorization.
- Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.
- I understand that, if a person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and not and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

____ ________________________________
Signature of patient or authorized person by law Date

_____________ # of pages copied _____________ Records Fee _____________ Date Mailed / Faxed / Picked Up
Records sent by: ____ per Dr. Dan Coverdell's consent.