Release of Medical Records

Patient

Name: ____________________________ Patient ID: __________________________

Phone: ____________________________ Email: __________________________

Address: ____________________________

Transfer From

Doctor: ____________________________ Clinic: __________________________

Fax: ____________________________ Email: __________________________

Phone 1: ____________________________ Phone 2: __________________________

Address: ____________________________

Transfer To

Recipient: ____________________________ Company: ________________________

Fax: ____________________________ Email: ________________________

Phone 1: ____________________________ Phone 2: ________________________

Address: ____________________________

Authorized Information to Disclose

Surgeries/Operations

Diagnoses

Prescriptions/Medications

Alternative Treatments

Mental Health Records

Alcohol/Drug Use Treatments

Sexual Health Records

Other:_____________________

Method of Transfer

Fax

E-mail

U.S. Mail

Other:_____________________

Reasons for Disclosure

Legal Requirement

Insurance Claim or Dispute

New Care Provider

Specialist Consultation

Second Opinion

Other:____________________

I, the patient, understand that I may revoke my consent, in writing, at any time. I understand that my information will be held in the strictest confidence and will be read, shared, and held by no parties other than those who transfer the information and those who receive it.

____

(Patient's Signature)

____

(Doctor's Signature)

____

(Date)