

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record.

*(Name of Patient)*

**Patient’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Information Requested:**   Immunization Record                 Labs (from the last 3 years unless otherwise noted)                     Problem List                   EKG   Imaging Studies (x-rays, US, MRI, CT, etc.)         Diagnostic studies (echocardiograms, stress tests, cath, EEG, etc.)                  Pathology reports   Mammograms              Pap smears   Consult Note (most recent)     Operative Reports       Progress Notes             Discharge summary |
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| **Purpose of Release: Provider Change** |
| **The Information is to be provided to: Provider Name and Contact Information:**  **R-Health – Ewing**  **34 Scotch Rd**  **Ewing, NJ 08628**  **Phone: (609) 498-7670**  **Fax: (609) 385-4150** |
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1. I understand that this authorization will **expire** on *(insert date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*.
2. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *(insert name of practice)* in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

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Patient’s Signature or Patient’s Representative Date

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Printed Name of Patient’s Representative Relationship to Patient

# YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

***Under HIPAA with patients’ written request, records must be provided within 30 days of a request.***

***Under House Bill 300 Texas Law with patients written request, records must be provided within 15 days of a request.***