primarycare
HEALTH PARTNERS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize PRIMARY CARE HEALTH PARTNERS to release medical information as described below:

Patient Name:_____ Patient Date of Birth:_____
Patient Street Address:_____
Patient City:_____ State:_____ Zip: _____ Phone:_____

I hereby authorize records to be released to:

Name: _____
Street Address: _____
City: _____State:_____Zip: _____
Phone #:( ) _____ Fax #: ( )_____

For the purpose of:

- ☐ Transfer of care out of practice
- ☐ Disability/SSI
- ☐ Insurance
- ☐ School/Camp
- ☐ Other (please specify)_____

Reason for leaving:

- ☐ Moving
- ☐ Transitioning to adult practice
- ☐ Dissatisfied
- ☐ Other (please specify)_____

I authorize my medical information to be released for the following time period:

☐ All Past, Present, and Future Dates **OR** Specify Date Range _____to_____

I authorize the release of:

☐ My complete health record (including records relating to mental healthcare, HIV or AIDS, and treatment of alcohol or drug abuse)

OR

☐ My complete health record **with the exception of** the following information:

☐ Mental Health ☐ HIV or AIDS ☐ Drug/Alcohol

(Note: If you choose an exception, we may need to schedule time to discuss your request.)

Complete **ONLY IF** requesting records be given directly to you:

I request the medical information be distributed using the following means:

☐ Patient Portal ☐ Paper Sent By Fax ☐ Paper Sent By Mail ☐ Paper (will pickup)
☐ CD/USB Flash Drive (will pickup) Other_____

By signing this release, I understand that:

- Requests may be subject to fees at rates pursuant to State regulations (e.g. paper copies, CD/USB downloads).
- I may revoke this authorization by notifying the health center in writing.
- Unless otherwise revoked, this authorization will expire 1 year from the Consent Date as signed below.
- Information used or disclosed pursuant to the authorization may be subjected to re-disclosure by the recipient and may no longer be protected by federal or state law.

<Patient full name>

_____ _____
Patient Signature (18 years or older) Consent Date

_____ _____
Parent, Guardian, Legal Representative Signature Consent Date