Request for Records Release

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ LAST 4-DIGITS OF SSN _____

_____ PHONE # _____

FROM:	**TO:**
Physician/Facility: _____	Physician/Facility: _____
Address: _____	Address: _____
_____	_____
Phone # _____	Phone # _____
Fax # _____	Fax # _____

INFORMATION TO BE RELEASED

□ Complete Medical Records
□ Recent H & P
□ Lab Reports
□ Radiology Reports
□ Hospital Reports
□ Last 3 Visits

□ Other:

REASON FOR THIS REQUEST

□ Transfer of Care (*Please provide a brief reason below*)
□ Change in Health Insurance
□ Patient Request (Personal Use)

□ Other:

METHOD OF DISCLOSURE

□ Pick Up (Name of Individual who will pick up your records):

_____

□ Fax #: _____

□ Mail to: _____

_____

Description of information you **DO NOT** authorize to be disclosed if any: (Subject to Provider's approval)

***** PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS. *****

Request for Records Release

By signing below, I certify that:

- I understand that I may inspect a copy of the records being disclosed
- I understand that unless excluded and noted herein the information being disclosed may contain sensitive information such as sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, physical abuse, or treatment for drug and alcohol abuse and psychotherapy notes.
- I understand that this authorization will expire in 3 months following the date of this authorization.
- I understand that I may revoke this authorization at any time (except to the extent that the information was already disclosed on reliance on this signed authorization) by notifying the provider's office in writing.
- I understand that if the person or organization that receives information is not covered by privacy regulations, the information may be disclosed and would no longer be protected.
- I understand that there may be a fee for copying/ supplying medical records. Middletown Family Care Associates, LLC follows the state regulations in regards to the fee schedule for copying charts.
    - $2.00 per page for pages 1 – 10
    - $1.00 per page for pages 11 – 20
    - $.90 per page for pages 21 – 60
    - $0.50 per page for pages 61 and above
- I understand that I have the right to receive a copy of this form.
- I understand that photo ID is required if the medical records are being picked up by another individual

I authorize the release of all information indicated. I release Middletown Family Care Associates, LLC from all legal responsibility and/or liability that may arise from the release of the records I have specified.

PATIENT NAME	DATE
DOB	ADDRESS
PHONE #	
X PATIENT/PARENT/GUARDIAN/CAREGIVER SIGNATURE	RELATIONSHIP TO PATIENT