FAMILY MEDICAL HOME, PLLC

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
(An Incomplete Form will not be accepted)

Patient Name: _____

DOB: _____ SS#: _____ Phone: _____

Address _____

PATIENT MUST PROVIDE COMPLETE INFORMATION IN ORDER TO PROCESS	
Records From: (Name & Address) _____ _____ Fax: _____	**Records To:** (Name & Address) _____ _____ Fax: _____

Please send a copy of my records as indicated for date(s) of Treatment: _____
__ Office Visits __ Lab Reports __ H&P __ X-ray Reports
__ Discharge Summaries __ Immunization History __ Other __ All Records

Purpose for releasing medical information _____
I will do what I can to assist in the expeditious transmission of this request.

Signature of Patient, Parent/Guardian _____
Witness _____ Date _____

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Signature of Patient: _____
Signature of Parent/Guardian: _____
Witness_____ Date: _____

Permission to FAX records for urgent care or medical emergency? __ Yes __ No