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Patient Records Release and Authorization Form

Instructions to the patient: Please complete and provide to the above practice. Applicable fees may be collected in advance. You may request a copy of this completed form.

Print Patient's Full Name: _____

Requested by: [ ] Patient [ ] Parent/legal guardian [ ] Personal representative of the patient

Photo ID and other proof of representation may be required

If requestor is not the patient, print full name, address and telephone number *of the requestor*:

_____

I request: *(check one only; complete another form for each additional request)*

[ ] Inspection of requested patient record.

[ ] A copy of requested patient record: [ ] for myself [ ] to be sent to another — n*ame & address:*

[ ] An electronic copy of requested patient record: [ ] for myself [ ] to be sent to another — *name & address:*

_____

Electronic format requested:

(We can discuss an acceptable electronic format if the requested electronic format is not available at our practice).

[ ] Please send requested record to me via *unencrypted* email. I recognize that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties.

Email address:

[ ] A written summary of requested patient record. I agree to pay in advance a fee in the amount of $ _____.

Describe the requested records, including the approximate dates of the records:

_____

_____

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as the patient has specifically provided below:

_____

_____

I hereby authorize this practice to release information contained in the health record as described on this form.

Signature: _____

OFFICE USE ONLY

Date request received _____ Received by_____

Type of identification and documentation reviewed to verify requestor's status as parent, legal guardian or personal representative* of the patient: