MEDICAL RECORDS RELEASE / REQUEST

Patient Date of Birth: _____/_____/_____ Patient SSN: _____-_____- _____

I, _____, hereby consent to the release of my medical records.
(Please print patient name)

I understand my records will be released TO / FROM:

Person/Entity_____
Address _____
Phone Number _____ Fax Number_____

Records that will be released are: *(please check all that apply)*

_____Entire chart including clinical notes, labs, prescriptions, images, etc. Dates:_____-_____
_____ Notes for all dates of service
_____ Notes for a specific date of service: _____
_____ Specific report: _____
_____ Billing information
_____ Other _____

Reason for Disclosure- Check all that apply

- Continuity of care/other provider
- Request of the patient identified above
- Attorney/client relationship
- Insurance
- Other(specify) _____ _____

I understand and acknowledge that if none of the above options are checked then my complete record will be disclosed. I understand that this authorization will remain in force until revoked by me in writing.

Specific Authorization for HIV/AIDS Testing, STD Testing, Drug and Alcohol, and Mental Health Records:
I acknowledge that the records to be released MAY include material that is protected by Federal Regulation 42 CFR, part 2 and is applicable to the above. My signature below authorizes the release of all information. Check here to suppress disclosure of this type of information:

I hereby acknowledge the above information and authorize the release of said medical records and/or billing information to the above referenced person/entity. I understand that these records are protected by law and cannot be disclosed without my permission.

Unless Revoked, this authorization expires in 180 days or on this Date:_____

Phone: 509-591-0070 8524 W. Gage Blvd., Bldg. A-1, Box 319

Fax: 509-396-9661 WWW.LYNX.HEALTHCARE Kennewick, WA 99336

_____ _____

Signature of Patient (or other responsible person) Date

_____

Relationship (if not the patient)

Completed By: _____

Rev 5/30/2018

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