# Request for Release of Medical Health Information/Records

Patient Name_____Date of Birth_____

Address_____City, State, Zip_____

Social Security Number_____Telephone (_____)_____

***Please Check Type of Information to be Released:***

___Complete Health Record
___History & Physical Exam
___Laboratory Test Results
___Photographs, Videotapes, CD-Rom
___Diagnostic studies/reports
___Consultation Reports
___diagnostic Imaging Reports
___Complete Billing Record
___Discharge Summary
___Progress Notes
___X-ray, films, images*
___Itemized Bill
___Other (please specify)_____

Covering the Dates of:_____

***Purpose for Release of Medical Records:***

___Further Medical Care
___Legal Action or Investigation
___Personal (at the request of patient)
___Insurance Eligibility/Benefits
___Changing Physician
___Other (please specify)_____

I understand that if the person and/or organization listed above is not in the health care industry, who are bound by Federal Privacy Standards, the health information released as a result of the authorization may no longer be protected by the Federal Privacy Standards allowing the possible release of my medical information without my authorization.

***(check box)***
***By completing this request, I authorize***

Name of Health Provider_____ **to Release my Protected Health Information to me and to deliver it to me via my secure patient portal account.**

*Actual films cannot be delivered electronically and will be sent to the patient or may be picked up in the office within 48 hours of request.