INCOMING RECORDS FROM PREVIOUS DOCTORS/FACILITIES

AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF HEALTH INFORMATION

Patient Name: _____ Birth Date: _____

Social Security #:_____ Phone: _____

I authorize the following Medical Office/Physician to release and/or exchange my health information as follows:

Practice/Physician Name: _____ Phone: _____Fax: _____

Street: _____City: _____

State: _____Zip Code: _____

Recipient:

_____

Name of person or organization receiving information Phone

_____

Address of person or organization receiving information Fax

Sensitive Information

If these records contain any information from previous providers or information about HIV/AIDS status, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information unless you check no.

_____**NO, do not release this sensitive information**

Purpose of this Disclosure:

☐ Transfer of Care	☐ Personal Use	☐ Continuity of Care
☐ Legal	☐ Workers Comp	

Specific Records/Reports to be disclosed. Please select from the options below & include service dates:

☐ History and Physical: Date(s) _____ ☐ Office Visits: Date(s) _____ ☐ Labs: Date(s) _____

☐ Alcohol/Drug Abuse Treatment: Date(s) _____ ☐ Consultations: Date(s) _____ ☐ Billing Record: Date(s) _____

☐ Psychotherapy Notes: Date(s) _____ ☐ Imaging Reports: Date(s) _____ ☐ Other: Date(s) _____

☐ Psychiatric Care/Assessment: Date(s) _____ ☐ HIV/AIDS Notes: Date(s) _____ (Specify) _____

I understand that this authorization is voluntary. I understand that treatment, payment, or eligibility for benefits cannot be conditioned on me signing this form unless it is for the sole purpose of obtaining information for a research study. I understand that this information is protected by federal and state privacy laws and may not be disclosed without authorization, unless required or permitted by law. I understand that I have the right to revoke this authorization at any time. The revocation will not be effective until delivered in writing to the Martha Jefferson Physicians Services Group facility that is in possession of my records. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, I understand that information, if present in my record will be disclosed as I have requested above. I understand that this authorization will expire in one year from the date of my signature below; or until _____ (not to exceed one (1) year).

_____ _____

Signature of Patient or Legal Representative Date of Authorization

_____ _____

Printed Name of Patient or Legal Representative Relationship to Patient

Created by: Medical Records Manager Date: 7/20/13

Revised 1/15/14, 5/11/16