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| **Records Obtain Form****(Authorization to OBTAIN Protected Health Information)*****!!!*** |

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| ***PLEASE MAIL OR FAX RECORDS.  Accepted Forms:  Paper, Thumbdrives.  WE DO NOT ACCEPT CDs*****PATIENT INFORMATION**

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| **First Name Last Name MI** |
| **Date of Birth Social Security Number** |
| **Street Address City State Zip Code** |
| **Home Phone Number Cell Phone Number Work Phone Number****( ) - \_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_**  |

**I authorize Berkeley Family Practice, LLC to OBTAIN my medical records FROM:**

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| **Name of Business / Person(s) / Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Street Address, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name of Business / Person(s) / Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Street Address, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name of Business / Person(s) / Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Street Address, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Information for Treatment Period:**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                                              **(Date)**                                             **(Date)****I authorize the release of the following Personal Health Information including but not limited to:*** Patient Identification / Diagnosis List ● Radiology Films & Reports
* EKG / Cardiovascular ● Physical Therapy Notes
* Pathology Reports & Lab Tests ● Billing Information
* Pulmonary Function Tests ● Occupational Therapy
* Office Notes / Physical Dictation

**Please initial beside each item:**\_\_\_\_\_ SENSITIVE INFORMATION: I understand that my record may include information relating to acquired immune-deficiency syndrome (AIDS) or  Human Immuno-Deficiency Infection, Psychological Assessment, Behavioral and/or Mental Health Services, Sexually Transmitted Diseases,  Alcohol and/or Drug Abuse and this information will be released.\_\_\_\_\_ RE-DISCLOSURE:  I understand that any disclosure of information carries with the potential for re-disclosure and the information then may not  be protected by federal confidentiality rules.\_\_\_\_\_ RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in  writing and that the revocation will not apply to information already released based on this information. \_\_\_\_\_ EXPIRATION: : I understand that this authorization will expire 12 months after signed unless an earlier date is advised here.\_\_\_\_\_ CHARGES: I understand that there may be a charge for releasing the requested information.  RecordQuest has been contacted to provide the  service and will bill you directly.  Questions may be directed to RecordQuest @ 888.300.7410.**I HAVE READ THE ABOVE STATEMENTS AND POLICIES OF BERKELEY FAMILY PRACTICE, LLC AND BY SIGNING BELOW, ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF THE SAME.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient or Legal Representative **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Description of Legal Representative’s Authority (attach necessary documents) |