BERKELEY FAMILY PRACTICE, LLC

Jeffrey Santi, MD • Jeremy Ackermann, DO • Sarah Heincelman, MD • Samuel Adams II, DO •
J. Dan Flaugher, MD • Margaret Sorrell, DO • Eric Lloyd, PA-C • Ashlyn Burns, PA-C •
Britton Tucker, PA-C • Jana Chinners, PA-C • Jacob Sooter, PA-C

Phone 843-761-8800 • Fax 843-761-8824

Records Obtain Form
(Authorization to OBTAIN Protected Health Information)

!!! PLEASE MAIL OR FAX RECORDS. Accepted Forms: Paper, Thumbdrives. WE DO NOT ACCEPT CDs !!!

PATIENT INFORMATION

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 <u>OBTAIN</u> my medical records <u>FROM</u>:

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: _____ (Date) to _____ (Date)

I authorize the release of the following Personal Health Information including but not limited to:

- Patient Identification / Diagnosis List
- EKG / Cardiovascular
- Pathology Reports & Lab Tests
- Pulmonary Function Tests
- Office Notes / Physical Dictation
- Radiology Films & Reports
- Physical Therapy Notes
- Billing Information
- Occupational Therapy

<u>Please initial beside each item:</u>

_____ 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)